

**UNIVERSITY OF THE WESTERN CAPE**

**FACULTY OF COMMUNITY AND HEALTH SCIENCE**

**RESEARCH REPORT**

**Title: The development of a model of emotional support for undergraduate nursing students working in mental health care settings**

**Student name:** Penelope Dawnette Martin

**Student number:** 3080353

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**Supervisor:** Professor FM Daniels

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Model development

Student nurses

Theory generation



## ABSTRACT

The mental health care environment is a stressful environment because of the environment, perceived unpreparedness of students and the emotional demands placed on the students which are inherent in the nature of the work. The use of the self as a therapeutic tool also presents challenges for students. Whilst researchers have identified supportive interventions and strategies to address students support needs in mental health care settings, these interventions/strategies focus on meeting clinical learning objectives with the assumption that if the student learning needs are met, they will feel emotionally supported. Literature and experience indicates that it is imperative that in this field of study, students should be prepared to cope emotionally with the demands of mental health work.

The *aim* of this research was to develop a model of emotional support for student nurses working in mental health care settings. A *theory-generating design* based on a *qualitative, explorative and descriptive* research approach was used to achieve the aim of the study. Purposive sampling was employed to select participants namely: students, educators and clinical staff who met the eligibility criteria. A sample of 40 students, nine educators and nine clinical staff who worked in the four psychiatric hospitals and community mental health clinics in the Western Cape participated in the study. Data collection was by means of focus group interviews (students) and in-depth individual interviews (educators and clinical staff).

Data was *analysed* by means of Tesch's method of content analysis. The model was developed by means of the four steps of the theory generation process. Step one was concept development which consisted of two sub-steps namely concept identification and concept definition. A total of 22 concepts were identified which was further synthesised into six main concepts. The main concepts which were used to

develop the model were: positive self-concept; positive work environment; academic and professional development; effective communication; formal and informal supportive interventions and collaboration between the Higher Education Institution and the mental health care setting. Step two of the theory generating process was model development. These main concepts were placed in relation with each other which formed an emotional support model for students working in mental health care settings. Step three was model description. The model was described using the three phases of interpersonal communication namely orientation phase, working phase and the termination phase. A visual application of the model which depicts the main concepts, the process and the context was shown. Step four dealt with the development of the guidelines for the implementation of the emotional support model. A *critical reflection* of the model was done using five criteria for model evaluation according to Chinn & Kramer. *Trustworthiness* of the data was ensured by means of applying Guba' model of truth value, applicability, consistency and neutrality. Reflexivity was used by the researcher to further enhance trustworthiness. Permission to conduct the study was obtained from the relevant authorities. The *ethical principles* of respect for human dignity, beneficence and justice were applied throughout the study. Limitations were identified and recommendations for nursing practice, education concluded the study.

## DECLARATION

I declare that “The development of a model of emotional support for undergraduate student nurses working in mental health care settings” is my own work, that it has not been submitted for any other degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: Penelope Dawnette Martin

Date: December 2013

Signed: .....



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*P*lease *A*cept my *G*ratitude

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ABBREVIATION	MEANING
B Nursing	Baccalaureus of Nursing (Degree)
HEI	Higher Education Institution
SANC	South African Nursing Council



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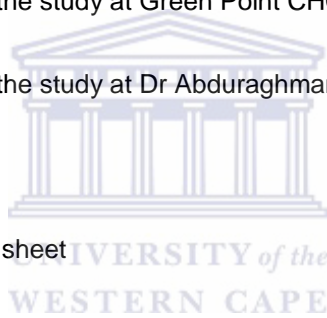


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# CHAPTER 1

## ORIENTATION TO THE STUDY

### 1.1. INTRODUCTION

The mental health care environment is a stressful nursing environment for health care workers especially student nurses (Tully, 2004; Prymachuk & Richards, 2007; Morrissette & Doty-Sweetnam, 2010). Factors that may contribute to the stress experienced by student nurses include, amongst other environmental factors, educational preparedness and emotional demands inherent to the nature of the work. Environmental factors are issues related to the setting that the student cannot control, such as the shortage of skilled staff and the stigma associated with mental illness (Kipping, 2000; Warne & McAndrew, 2004). Shortage of skilled nursing staff is a global problem. However, the recruitment and retention of staff to address the staff shortage in mental health care settings are compounded by the stigma related to mental health nursing. Mental health nursing is not seen as 'real nursing' as the work is perceived to be routine and mundane (Happell, 1999; Wells, Ryan & McElwee, 2000). This means that mental health nursing is often perceived as having a lower status than general nursing (Munnukka, Pukuri, Linnainmaa & Kilku, 2002). Moreover, people hold views that people with mental illness are all violent, unpredictable and sometimes responsible for their own illness. This negative and stigmatising view is often also held by student nurses (Frisch & Frisch, 2011).

In anecdotal reports, students working in mental health care settings in the Western Cape stated that they were afraid of the patients. The fear of the unexpected, the

locked wards and the stories they had heard about mentally ill patients from the clinical staff appeared to exacerbate their own insecurities. Notwithstanding the orientation provided to prepare students for the clinical placement, they remained fearful. This may be due to the stigma associated with mental illness which is perpetuated by media portrayal of dangerous and violent mentally ill persons.

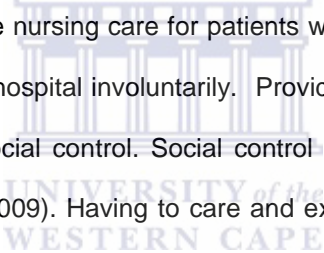
The placement of students in the clinical settings may be perceived by mental health care staff as an additional load in an overburdened environment. Staff may not have time to address the students' learning needs. In addition, Bunce (2002) asserts that students might not know what nurses do and thus have unrealistic expectations of the clinical placement. Students could possibly feel that they are being used as cheap labour to do menial tasks. The perceptions of the staff, especially those who have been trained in the past, and the expectations of the students may result in miscommunication. This miscommunication could result in the students experiencing emotional distress as qualified staff put pressure on them. Menzies (1988) in her seminal work of social systems as a defence against anxiety alluded to the recognition of student distress. She stated that student distress must be addressed because, as she aptly concluded, 'nursing is a profession where the young are eaten'.

Emotional distress in students may be precipitated by educational unpreparedness and thus contribute to the perception that the mental health care environment is stressful. This may include perceived inadequate preparation for the nature of the work and the perceived lack of support and thus unpreparedness for the complexities of mental health nursing (Gerrish, 2000; Magnussen & Amundson, 2003; Ewashen & Lane, 2007). Some students may lack clinical confidence and consequently think that

they cannot work in mental health care settings. This is usually based on lack of experience in working in mental health care settings (Bell, Horsfall & Goodin, 1998).

During the clinical placement, students are expected to use tools of self and knowledge to render care. This implies that students need communication skills, knowledge of nursing, psychiatric and psychological theory (Johnson & Frisch, 2011).

These skills enable them to conduct mental health status examinations, engage in counselling, and individual and group discussions about managing life stressors. The student nurses' sense of personal vulnerability may increase when caring for patients whose mental illness was as a result of life stressors. They then become aware of the risks that stressors can affect in their own lives (Shumaker & Brownell, 1984).



Students are also expected to provide nursing care for patients with mental illnesses who may have been admitted to the hospital involuntarily. Providing nursing care to these patients includes exercising social control. Social control refers to managing aggressive patients (Gray & Smith, 2009). Having to care and exercise control over patients with mental health problems leads to emotional distress in all involved (Cropanzano, Rupp & Byrne, 2003). Emotional distress may manifest in emotions such as anxiety, fear and doubt which inhibit learning (Kayes, 2002).

The emotional demands of mental health nursing may also be related to the interpersonal relationship, which is the central focus of mental health nursing care (Frisch & Frisch, 2011). This relationship between the student and the patient is a therapeutic process where interventions are planned and implemented. Within this process students have to use themselves in such a way that they become a therapeutic instrument in the intervention process. This provides the opportunity for person-to-person connection (Frisch & Frisch, 2011). Barker (1992, 62) alludes to the

therapeutic process as a 'potential emotional minefield' - as the student has to have a greater sense of self-awareness and self-understanding. It is through knowing themselves that the students are able to care for the mentally ill. Self-awareness is the ability to recognize one's emotions and values and being able to realistically assess one's strengths and limitations (Patrikakou & Weissberg, 2006). This infers that one begins to evaluate oneself. This evaluation is important in the regulation of emotions (Papalia & Olds, 1995). However, Baker (2007) avows that the sense of self is developed from experience and feelings which are modulated through cognition and emotion as life develops. Through these experiences and feelings, it is expected that students develop a degree of self-awareness that is necessary to build relationships and care for the mentally ill (Stuart & Laraia, 2001). Self-awareness develops as a result of cognitive maturation and self-exploration. If during infancy the experience of a consistent, loving caregiver which supported the attempt at autonomy, there is a greater chance of developing a positive self-concept during later developmental stages (Louw & Louw, 2007). Whilst a positive self-concept may be the ideal characteristic to have when working in mental health care settings, students differ in terms of what is construed as a well-developed sense of self and thus must make use of strategies to regulate their emotions (Stuart, 2009).

Personal attributes such as self-acceptance, self-respect and the capacity to give and receive love, among others, are also included in the use of the self and are thus necessary to develop a therapeutic relationship with mentally ill patients (Stuart & Laraia, 2001). The use of the self may present challenges for students who have an underdeveloped self-concept. They may feel insecure and question their ability to help people with mental illness (Stuart, 2009).

The use of the self is complex and therefore students need to be supported in sustaining a well-developed sense of self - thereby ensuring that they have the

capacity to deal with the emotional demands placed on them in caring for people with mental illness. The researcher, a lecturer in psychiatric nursing at a higher education institution, observed that some students appeared emotionally distressed when working with mental ill patients. They reflected on patients' personal trauma histories and the resultant diagnoses of mental illnesses in these patients. This was significant especially when the patients were of the same age as the students. The students indicated that they too may become mentally ill. These observations are supported by several research findings (Morrissette 2004; Stuart 2009, Tully, 2004) which indicated that student nurses are rarely prepared for the realities of direct patient care in mental health care settings. Although students enter the mental health care setting with some theoretical knowledge and role play experience, they report feeling overwhelmed and emotionally traumatised by what they see and hear. If learning is to occur then emotional health and well-being is important (Warwick, Maxwell, Simon, Statham & Aggleton, 2006).

It appears as if the sources of stress relate to the specific work setting as well as to the special demands of clinical care in mental health nursing. These stressors may contribute towards students' resistance towards mental health nursing and discourage newly qualified nurses from choosing mental health nursing as a career (Cleary & Happell, 2005; Gray & Smith, 2009). One of the ways to address these challenges that students experience is by providing support. Warwick et al, (2006) maintain that it is important to offer students a range of supportive interventions so that they can choose those with which they feel comfortable. Educators and clinical staffs' role in supporting students include but is not limited to role modelling ((Twentyman, 2006); having a 'buddy system whereby recently qualified nurses work with students (Bunce, 2002); however Ewashen & Lane (2007) contend that when

students are distressed, pedagogic boundaries become blurred as educators and clinical staff face the challenge of being 'counsellors' or 'caring educators'.

Formal supportive interventions such as preceptorship (Morton-Cooper & Palmer, 2000), mentorship (Prevosto, 2001), peer support (Mead, Hilton & Curtis, 2001), group supervision (Saarikoski, Warne, Aunio & Leino-Kilpi, 2006) and university-based student support services (UWC, 2009) have been identified to address the support needs of students for educational purposes. Preceptorship involves the teaching, instructing, supervising and role modelling to enhance learning by an identified experienced practitioner (Morton-Cooper & Palmer, 2000). Experienced nurses giving student nurses advice and sharing their experiences is known as mentorship (Prevosto, 2001). Preceptors and mentors could be registered nurses working in mental health care settings where students are placed. Mead et al, (2001) states that peer support is a process whereby help is given and received by peers who have shared experiences of emotional and psychological distress. Essentially this means that nursing students who have worked in mental health care settings support their peers.

Student support services at universities focus on academic support, therapeutic services, student development, disability and leadership and social responsibility for the university population in general (UWC, 2009). These services provide short term help to students who are experiencing difficulties. Barre and Evans (2004) affirm that there may sometimes be a mismatch between university staff support paradigms and those of the student population. Students may need support which differs from the support provided by university staff. The mismatch may be the assumption arising from the formal supportive interventions - that if student learning needs are met, they may feel supported emotionally in the mental health clinical settings. However, these

interventions do not address specific aspects relating to self-awareness, emotional resilience and self-efficacy.

Some informal suggestions, based on personal experience and extant literature, to support students in the mental health clinical learning area is offered by Morrisette and Doty-Sweetnam (2010). These include having a well-constructed syllabus, reciprocal educator-student relationship; anticipating inappropriate student behaviour, educator introspection; policy and procedure transparency; maintaining personal boundaries; avoiding classroom confrontation; avoid meeting students alone and documentation of meetings and correspondence with students. However, these suggestions are not based on empirical research nor do they address the emotional needs of students in mental health care settings.

Several studies regarding students' experiences in the clinical practice area have been conducted. The foci of most of these studies have been on general nursing. Morrisette and Doty-Sweetnam (2010) claim that this may be because mental health nursing is not well known and thus receives less interest. The mental health care environment may be perceived by students as challenging and consequently emotional wellbeing may not warrant attention.

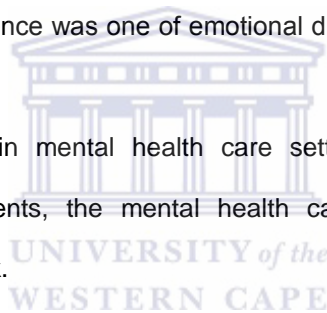
The most recent (2000 and beyond) literature on student nurses' experiences in mental health care settings emanates from the United Kingdom (UK), with a few studies conducted in Australia. Challenges in mental health focuses on the general organisational issues such as staff shortages, staff attitudes among others (Kipping, 2000; Henderson, Happell and Martin, 2007) and the nature of the work - for example the stress experienced by caring for the mentally ill (Tully, 2004; Prymachuk & Richards, 2007; Nolan & Ryan, 2008; Freeburn & Sinclair, 2009 ).

Literature regarding the experiences of students in mental health care settings in South Africa is limited. Like its global counterparts, South African studies focus on

the experience of student nurses in the general nursing clinical area. Organisational issues such as staff shortages and staff attitude are cited for both general (Lita, Alberts, Van Dyk & Small, 2002; Moeti, Van Niekerk and Van Velden, 2004) and mental health care settings (Van Rhyn & Gontsana, 2004). Aspects related to the lack of support around the education of general nursing students, such as poor theory-practice integration have also been cited by Mabuda, Potgieter & Alberts (2008). The recommendations from these studies include supporting students in clinical learning opportunities.

Recently, Janse Van Rensburg (2012) conducted a study to ascertain the experiences of student nurses working with mentally challenged individuals. She found that the students' initial experience was one of emotional distress but that they later reported emotional growth.

Although nursing students placed in mental health care settings share similar experiences to other nursing students, the mental health care environment is stressful due to the nature of the work.



## **1.2. BACKGROUND TO THE STUDY**

To contextualize the study, it is important to understand how the nursing programme in South Africa is offered in relation to other countries globally. Literature reviewed (O'Brien, Buxton & Gillies, 2008; Tully, 2004) reports that psychiatric nursing is offered in the first to the third year of the nursing programme globally.

### **1.2.1 Undergraduate nursing programmes in South Africa**

In South Africa, education and training of nurses are regulated by the South African Nursing Council (SANC). A four-year comprehensive nursing programme was established under the provisions of the SANC Regulation 425 of 22 February 1985.



The programme is offered at a college towards a diploma in nursing and at a university towards a baccalaureate degree. When students have completed the four-year comprehensive nursing programme, they are registered in the discipline speciality of general nursing, psychiatric nursing, community nursing and midwifery. As stated by the South African Nursing Council, the education and training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration shall have a minimum of 4000 clinical hours (SANC, 1985). The compulsory clinical hours are allocated per discipline of which psychiatric nursing must show evidence of six hundred (600) hours of clinical learning. These hours include skills development in clinical laboratories, community outreach projects and placement in mental health care settings. The number of clinical hours are specified for inpatient (mental illness and intellectually disabled) mental health care in acute, long term, admission, psychogeriatric, substance abuse units amongst others, and community mental nursing. Student nurses have pre-set clinical objectives which they have to attain. In addition to attaining these objectives, they are expected to develop clinical skills which will enable them to practice as mental health care nurses when they graduate.

### **1.2.2 Psychiatric nursing science for the degree programme at the University of the Western Cape**

At the University of the Western Cape psychiatric nursing is offered in the fourth year of the R425 nursing programme. However, in the second year of study students are introduced to psychiatric nursing by way of a theoretical module - Introduction to mental health. This module deals with basic mental health assessment and selected social conditions which may predispose individuals to mental illness, for example substance abuse and domestic violence. They also receive instruction on common

psychopathology such as depression. There is no clinical component attached to this module and students are not placed in the mental health care setting.

The rationale for placing final-year students in psychiatry is that students have been exposed to general placements and thus have gained experience in caring for ill patients. Students would also have completed theoretical modules in psychology, social sciences and human biology which would then serve as a basis for understanding psychopathology and interpersonal skills. The assumption is that by the time students reach the fourth year of study, they have learnt some of the special skills related to interpersonal techniques to assist mentally ill and intellectually disabled patients in adapting to difficulties. This, however, means that students are placed in the mental health care setting for the first time in the fourth year of study. This is significant as it may be the first time that students see a psychiatric hospital. The students' exposure to mentally ill patients may have occurred in the general placements, as these are the first point of entry for the mentally ill into the health care system. Patients are assessed and transferred to psychiatric hospitals depending on the severity of their mental condition.

The clinical aspect is conducted at the four psychiatric hospitals in the Western Cape and community mental health clinics. The aim of the clinical placement is to integrate theory, learnt in the classroom, with the practice and to ensure that students meet the SANC clinical hour requirement. Certain psychiatric hospitals offer mental health care services to both mentally ill and intellectually disabled individuals - while others focus on intellectual disability only. Community mental health care services cater for both mentally ill and intellectually disabled individuals. The students' clinical programme endeavours to ensure that a student is exposed to all these facilities, to ensure a comprehensive understanding of mental health care which includes in- and outpatient care. Due to the nature of the degree programme, the clinical and

theoretical components are synchronized and integrated. This means that students attend class for two days and spend three days in the mental health care clinical setting per week. Student rotation occurs between three and four weeks to ensure that all the learning requirements are achieved.

While this system supports the integration of theory and practice, students do not have the opportunity to spend long periods in the mental health care setting. This could result in them being unable to form relationships with staff and patients, and consequently are perceived as outsiders. Wards are overloaded with students amidst staff shortages, as a consequence of the competition for clinical learning opportunities in mental health care settings by students with similar needs.

The teaching staff involved in the delivery of the psychiatric nursing science programme includes university appointed clinical supervisors and lecturers. Clinical supervisors are responsible for the clinical accompaniment of students in the mental health care setting. They are tasked with ensuring that the students' learning objectives are attained and to assist students in theory-practice integration. The clinical supervisors are based at the mental health care settings and are allocated to supervise an average of 30 students per clinical practice rotation.

Lecturers are responsible for the facilitation of student learning. The lecturers' primary role is to impart psychiatric knowledge thereby ensuring that students are taught the theoretical aspects of psychiatric nursing. They assist the clinical supervisors with teaching psychiatric nursing skills. Lecturers conduct student accompaniment for a period of eight hours per week in the clinical setting.

A question that emanates from the researcher's observation, anecdotal evidence and the literature about the mental health care environment is: What can be done to support nursing students emotionally to enable them to work in mental health care settings? The researcher is of the opinion that one of the ways to address the

challenges student nurses experience in the mental health care setting, is by providing the needed support. There are existing student support services at the university, for example academic support and therapeutic services are offered to the general university student population. The challenge however, is that these interventions focus on students' learning needs and general mental wellbeing. They do not necessarily address specific aspects relating to self-awareness, emotional resilience and self-efficacy - neither does it offer emotional support for students working in mental health care settings.

### **1.3. RESEARCH PROBLEM STATEMENT**

The theory and practice demands placed on the students by SANC, university rules, regulations and policies, the curriculum design and the students' perceptions and expectations of the mental health care environment appear to cause emotional distress in students'. The emotional demands inherent in the nature of the work in mental health care settings appear to exacerbate students' distress.

The use of the self as a therapeutic tool also presents challenges for students who present with an underdeveloped sense of self. Whilst there are existing supportive interventions and strategies to address students' needs in mental health care settings, these interventions/strategies focus on meeting the clinical learning objectives (Morton-Cooper & Palmer, 2000; Prevosto, 2001; Mead, Hilton & Curtis, 2001; Saarikoski, Warne, Aunio & Leino-Kilpi, 2006; UWC, 2009). This is predicated on the assumption that if the students' learning needs are met, they will feel emotionally supported. The obvious lack of emotional support strategies for students working in the mental health care setting has motivated the researcher to explore the experiences of student nurses, educators and clinical staff in regard to the students' emotional challenges and their emotional support needs – in order to develop a

comprehensive model for the emotional support of student nurses working in mental health care settings.

#### **1.4. AIM OF THE RESEARCH**

To develop a model of emotional support based on the identified emotional needs of students working in mental health care settings.

#### **1.5. OBJECTIVES THE STUDY**

- To explore nursing students' emotional challenges when working in mental health care settings.
- To explore students' emotional support needs when working in a mental health care setting.
- To explore how educators and clinical staff perceive students' coping in the mental health care setting, as a means of ascertaining their views of the students' emotional challenges in the mental health care setting.
- To describe the strategies which education and clinical staff use to support students working in mental health care settings
- To develop an emotional support model for students working in mental health care settings - based on students' self-identified emotional needs, the students' emotional needs as identified by the education and clinical staff and the existing strategies of student support.

#### **1.6. RESEARCH QUESTIONS**

- What are the emotional challenges experienced by students working in mental health care settings?

- What emotional support do students propose they need in a mental health care environment?
- How do education and clinical staff perceive students' coping in the mental health care setting?
- What strategies do education and clinical staff use to support students working in mental health care settings?

### **1.7. SIGNIFICANCE OF THE STUDY**

This information will be used to develop an emotional support model that may make the following contributions, namely:

- To bridge the gap in the existing body of knowledge, as the studies on the emotional experiences of students working in mental health care environments in South Africa are limited.
- To impact nursing education programmes regarding the preparation of students for mental health nursing, thereby enhancing the students' experience of mental health nursing and thereby contributing to the recruitment and retention of nurses in mental health care.
- To assist students to acquire the necessary skills and competencies to work in the mental health care environment, which is known to create anxiety and possibly elicit reactions to their own person life experiences and occurrences.
- To enhance the image and social positioning of nursing by promoting a caring ethos in nursing students.
- To develop a model that will not only focus on supporting students in meeting their learning objectives but will provide emotional support to enable them to cope in the stressful mental health care environment.

- To offer guidance to the HEI and clinical sites on strategies regarding student emotional support.

## 1.8. CLARIFICATION OF CONCEPTS

The following terms or concepts are defined or clarified for use in this study

### (i) B Nursing Degree

A B Nursing degree is a four year honours equivalent degree which prepares nursing professionals for nursing and midwifery practice (South Africa, 2005).

The four-year undergraduate Baccalaureus Nursing Degree offered at the participating university.

### (ii) Clinical staff

Clinical staff are professional nurses who are qualified and competent to independently practice comprehensive nursing in a manner to the level prescribed and who are capable of assuming responsibility and accountability for such practice (South Africa, 2005).

In this study clinical staff refers to professional nurses rendering nursing care to mentally ill patients at the four psychiatric hospitals and community mental health clinics in the Western Cape.

### (iii) Coping

Coping is “the constantly changing cognitive and behavioural efforts to manage the specific external or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984).

Coping in this study refers to the cognitive and behavioural efforts of students when they evaluated encounters in the mental health care setting as being stressful - to solve emotional issues and reduce stress.

(iv) Clinical accompaniment

This refers to the follow-up that students receive from the educators who visit the mental health care setting, to integrate the mental health theory with practice in the mental health facilities in Western Cape.

(v) Educators

In this study, educators refer to two categories of staff employed by the university in the study:

(a) Nurse educators, are professional nurses who have qualified as nurse educators and who teach psychiatric nursing science. They are referred to by the students as lecturers.

(b) Clinical supervisors are professional nurses who provide clinical supervision to student nurses when placed in the mental health facilities

(vi) Emotional challenges

Emotional challenges refer to the issues and events which test the students' abilities or coping resources, which may be assessed by students as being positive or negative.

(vii) Emotional support

Emotional support refers to the feelings of reassurance, belonging and caring that students experience while working in mental health care settings.

(viii) Experiences

Experiences refer to the total persons perceptions, feelings or memory (([www. Merriamwebster.com](http://www.Merriamwebster.com)))

In this study experiences are the emotional challenges, coping and support needs of students working in mental health care settings.



(ix) Intellectually disabled patients

This is a reference to children and adults with an IQ below 70 and impairment in physical, social or interpersonal functioning (APA, 2000). They are patients at two psychiatric hospitals in the Western Cape.

(x) Higher education institution, institution and university

A higher education institution is described as any institution that provides higher education on a full-time, part-time or distance basis, which has been merged, established or declared or registered as a higher education institution under the Act (South Africa, 1997).

This refers to the participating university in the Western Cape which offers the B Nursing degree for nurse education and training on a full-time basis.

(xi) Mental health care / psychiatric nursing

Mental health care is a wide variety of treatment approaches that foster and promote mental health and prevent mental conditions arising in at-risk individuals (Flisher, Jansen, Lund, Martin, Milligan, Robertson & Winkler, 2003).

In this study, mental health care provided by psychiatric institutions and community health centres in the Western Cape - refers to the care, treatment and rehabilitation that the nurse provides to patients who are mentally ill to promote mental well-being and to prevent mental illness. The term mental health care may be used synonymously with psychiatric nursing.

(xii) Mental health care settings

Mental health care facilities are the main service areas for the provision of mental health care, treatment and rehabilitation (Flisher et al, 2003).

In this study, mental health care settings refers to the mental health facilities which consist of the four psychiatric hospitals in the Western Cape as well as

the community mental health centres which provide mental health care services to mentally ill and intellectually disabled patients

(xiii) Mental illness

Mental illness is "...a clinically significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning), a significantly increased risk of suffering death, pain, disability, or an important loss of freedom and is not merely an expectable response to a particular event." (APA, 2000)

In this study, mental illness refers to the behavioural and psychological signs and symptoms individuals present with for care, treatment and rehabilitation at mental health facilities in the Western Cape.

(xiv) Model

A model can also be described as a mental or diagrammatic representation of a phenomenon which is systematically constructed and which assist practitioners to organize their thinking about what they do in practice for the benefit of the patients and the profession (McKenna, 1997). Chinn and Kramer (2004) define a model as the symbolic representation of empirical evidence which is expressed in words, pictures or graphic diagrams.

In this study, a model refers to a diagrammatic representation of identified concepts related to emotional needs and the relationships to explain the phenomenon of emotional support.

(xv) Needs

Needs are requirements based on real or imagined deprivation (Harper & van Vuuren, 2012). Needs are physiological or psychological requirements for the well-being of an organism ([www. Merriamwebster.com](http://www.Merriamwebster.com))

In this study, needs refer to the psychological requirements for the emotional well-being of student nurses.

(xvi) School of Nursing

In this study, school of nursing refers to the nursing unit at the higher education institution in the Western Cape responsible for the education and training of the undergraduate nurses participating in this study.

(xvii) Student nurse

A student nurse is a person who is “following a programme of study in a nursing education institution” (Nursing Act No. 33 of 2005).

In this study, student nurses refer to fourth year student nurses completing the basic degree in nursing at a higher education institution in the Western Cape.

## **1.9. PARADIGMATIC PERSPECTIVE**

Babbie (2007) asserts that a paradigm is a ‘framework, viewpoint or worldview based on peoples’ philosophies and assumptions about the social world and the nature of that knowledge, and how the researcher views and interprets material about reality and guides the consequent action to be taken’. The paradigmatic perspective is thus the collection of theoretical, meta-theoretical and methodological assumptions that guide the research process (see 5.8).

### **1.9.1 Meta-theoretical assumptions**

Student accompaniment, which strives to develop a caring ethos, is a central construct in nursing. Its anthropological perspective, according to Kotze (1998), underpins the rationale for emotional support of students in mental health care settings. The central assumption of this perspective is that man - and therefore the student - is seen as a holistic being which implies that the body, psyche and spirit are

considered. Body refers to man's physical presence; psyche is the centre of man's thinking, intellect, awareness, emotions, perceptions and experience; whilst spirit represents man's humanness which manifests as personality. Personality is the externalisation of man's physical and psychological potential. Within this perspective, accompaniment is a deliberate systematic intervention by the nurse to assist others and self to overcome the need for health and support (Kotze, 1998). Kotze (1998) states that in order for the student nurse to function within the accompaniment role, and especially within the mental health care environment, the following relevant theoretical statements are deduced from the theory and are used in this study:

- The student nurse working in the mental health care setting is a person functioning as an integrated whole, body-psyche-spirit, in order to function optimally.
- The student nurse working in the mental health care environment interacts with both his/her external and personal world and thus the accompaniment role does not only assume knowledge and skills but also the therapeutic use of the self.
- In his/her inner or intrapersonal world, the student nurse has a world of co-existence. The assumption therefore is that the student nurse lives in encountering and communicative interaction with others. He/she gets to know him/herself through his/her fellow-beings and need them in his/her maturation.

Assumptions which emanate from the meta-theoretical statements include that – the student nurse can

- recover self-reliance
- assume responsibility for the development of a means to cope within the mental health care environment
- establish meaning in personal and student life in spite of circumstances in the mental health care environment (Kotze, 1998).

The above summarized anthropological perspective on accompaniment purports that the student nurse needs to be supported to become a self-reliant, responsible, professional individual - who has a sense of meaning in life which would enable him/her to cope within the stressful mental health care environment.

#### **1.10. RESEARCH METHODS**

A qualitative approach using an explorative-descriptive design was deemed most appropriate for the study. A theory generating design, as suggested by Walker & Avant (2005) and Chinn & Kramer (2004), was employed for model development. The research methodology is described in detail in chapter 3.

#### **1.11. DATA ANALYSIS**

An inductive approach to data analysis was used. Tesch's method of identifying themes in the data was utilized. The findings which emerged from step 1 were employed to develop an emotional support model which is step 2 of the study. A more detailed description hereof is provided in Chapter 3.

#### **1.12. OUTLINE OF THE THESIS**

The chapter sequence of this thesis is as follows:

Chapter 1 provides an orientation and rationale for the study. It also highlights the problem statement, aim, objectives and significance of the study.

Chapter 2 provides the theoretical framework which forms the basis of the study.

Chapter 3 refers to the methodology used in the study.

Chapter 4 provides a detailed presentation and an in-depth discussion of the findings. The literature control was used to place the findings in context with other

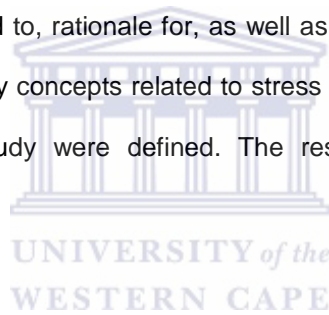
studies and therefore no separate literature review chapter was included in this thesis.

Chapter 5 provides the development process and a description of the emotional support model and guidelines for the implementation of the model in practice.

Chapter 6 outlines the conclusions, limitations of the study and provides recommendations based on the findings of the study.

### **1.13. SUMMARY**

Chapter one outlined the background to, rationale for, as well as the aim, objectives and the significance of the study. Key concepts related to stress and coping, as well as other concepts used in the study were defined. The research design and methodology were briefly described.



## CHAPTER 2

### THEORETICAL FRAMEWORK

#### 2.1 INTRODUCTION

It is averred in Shank (2006) that there is a place for the use of theory and theoretical frameworks in qualitative research if it assists with coordinating the richness of meaning in the qualitative inquiry. Henning, Van Rensburg and Smit, (2004:25) asserts that theoretical frameworks in research serve to “frame” the inquiry. Four options concerning theorising from qualitative data have been cited by Grbich (2007) which include:

- Having a pre-chosen theoretical position which informs one’s research and against which the findings of the research will be placed;
- The methodological underpinnings about the data and the process are followed;
- Researcher’s choice alludes to where the researcher wishes to provide a more abstract explanation of the research findings;
- Theory minimisation refers to where the interpretation is minimal and the data is displayed in such a way that the reader draws his/her own conclusions based on their own life experiences.

In this study, theory was used to position the study within the health science discipline. It enabled the researcher to present a discourse between the literature and the study. It assisted the researcher to direct the inquiry into the experiences of students working in mental health care settings by focusing on challenges experienced, coping and support, and identified needs.

Various theories/models on stress and coping from the myriad of existing models were reviewed. Three broad theories were selected as their focus is based on the core concepts related to this study. An exposition of the literature on emotion and the significance of cognition are referred to, in order to give credence to the philosophical paradigm discussed in chapter 1.

## **2.2 THE NATURE OF EMOTION**

Emotions have been studied from various perspectives. These include physiological, developmental, social or cultural, and behavioural perspectives. Physiological theorists believe that emotions have physical causes, consequently inferring that bodily responses are responsible for emotions (Izard, 1984). Developmental theorists purport that as individuals develop throughout life, their emotions change (Sroufe, 1996). According to Abu-Lughod and Lutz (1992), emotions from a social or cultural perspective emerge as social issues or in the meanings that individuals ascribe to the psychosocial process by means of language. Emotions described from a behavioural perspective are usually a response rather than a state (Strongman, 1996). De Houwer and Hermans (2010) assert that within all these perspectives of emotions, cognition has played a major role in emotion-processing to make sense of the stressful experience. There is also a constant interaction between cognition and emotion as individuals go about their daily lives.

Emotions are central to all human experiences and functioning. Common understandings of emotions are determined by the context in which they occur. Whilst the subjective experience of emotions differs from one person to the next, these emotions are described by using verbal descriptors which depict emotional functioning in the individual. Verbal descriptions include statements such as being



cut-off from emotions, emotionally distant and emotionally expressive (Stanley & Burrows, 2001).

### **2.3 EMOTION AND EMOTION CAUSATION**

In view of the complexity in defining emotions, Moors (2010) suggests that the term emotional episode would be more appropriate as it is inclusive of a range of emotion components. These components include cognition, feeling, being ready for action, bodily processes and a motor component. The functions corresponding to cognition are appraisal, monitoring of feelings, being ready for action – i.e. preparation and support, whilst the motor component corresponds with the function of taking action. Of all these components some may be necessary for emotions but Moors (2010) asserts that there is no one component that is unique. However, within the appraisal (cognitive) component Moors (2010) concurs with Lazarus (1984) that the emotional episode will occur if there is relevance to the person's goal, implying that the transaction must have significance for the person to warrant an emotional response. Gross & Thompson, (2007) identify three core features of emotion. These include the following:

- emotions arise out of the meaning a situation has for the individual and the relevance that the situation has for the goal of the individual;
- emotions are complex and which include changes in subjective experience, behaviour as well as central and peripheral physiology; and
- emotions force themselves upon our awareness thus making emotion regulation possible and necessary.

Emotion or emotional episodes can then be described as “experiences of arousal that are associated with physical activation, changes in behaviour and subjective cognitive events” (Harper & van Vuuren, 2012: 130).

There are few primary emotions. The paired primary emotions include fear-anger; joy-grief (sadness); disgust-trust (acceptance) and surprise-anticipation (expectancy) (Plutchik, 1962). Student nurses make use of this array of emotions to cope, whether or not it is adaptive or maladaptive, in the mental health care setting.

## **2.4 FUNCTIONS OF EMOTION**

Emotions are thought to have an adaptive or nurturing function. As a result of experiencing emotions protective processes are activated against situations which signify danger, threat or loss. These processes also seek emotional support to nurture human needs. Adaptive functions of emotion include attention shift, motivation arousal, social communication and precipitating behaviours (Stanley & Burrows, 2001). This implies that during a transactional encounter within the environment, emotion directs the individual's attention towards a relevant event and away from what is less relevant to the individual. Through cognitive interpretation of the event as one that elicits emotion, affective and behavioural responses are activated. These serve to resolve the situation thus promoting adaptation. Human emotions direct much of human functioning and are present in both interpersonal and personal behaviours. Emotions allow student nurses in mental health care settings to communicate the impact events have on them verbally, non-verbally and behaviourally. When they observe emotions in the mentally ill patients, their own empathetic emotional responses may be elicited which may allow students to engage in caring behaviours without experiencing the patient's emotions themselves (Stanley & Burrows, 2001). However, dysfunctional emotions may arise from interpretations of the psychosocial world. Anxiety which stems from perceived threats may interfere with the students' functioning and thus result in possible inability to display caring behaviour towards patients.

## **2.5 EMOTION REGULATION**

Emotion regulation is about how individuals influence their emotions and the experience and expression of these emotions (Gross & Thompson, 2007). In this study, emotion regulation means the way in which students deal with their emotions to make sense of their experience in mental health care settings. This may happen automatically or controlled and conscious or unconscious (Gross, 1999). Emotion regulation includes both intrinsic and extrinsic processes. This implies that regulating emotions in others is extrinsic and the self-regulation of emotions is an intrinsic process (Gross & Thompson, 2007). In this study, emotion regulation focuses on the intrinsic processes of how students self-regulate their emotions - to enable self-reliance in the cognitive process of making sense of their encounters in the mental health care setting. Gross (2001) developed a functional model which he refers to as a modal model of emotion regulation. The model specifies the processes in emotion generation which potentially target emotion regulation. This model is discussed for clarification of the emotional processes.

There are five points at which individuals can regulate their emotions within the modal model. These include (i) situation selection, (ii) situation modification, (iii) attentional deployment, (iv) cognitive changes and (v) response modulation.

### **Situation selection**

Situation selection refers to choices that are made regarding the manner in which situations are selected by the individual, to give rise to the experience of positive emotions. This is important for students placed to work in mental health care settings because based on prior knowledge, information from friends about the mental health care setting, or experience - they may choose where and who they want to work with. However, choice is not possible throughout the placement period as students have to

attain learning objectives in a variety of areas. These can be areas where long term patient care is rendered, acute patient care areas and the areas where patients with intellectual disability are cared for. Thus they are placed in wards or situations that may give rise to emotions that are experienced as difficult or stressful. Emotions can also be seen as a way of alerting one to take action to restore equilibrium. Choice is therefore not always an option for students in nurse education and training.

i) Situation modification

Modifying the external mental health care environment to avoid potentially distressing situations alters the emotional impact. Lazarus (1984) refers to this as “problem-focused coping” as a function of coping. Problem-focused coping changes the person-environment relationship by acting on the environment itself or on the person. The students’ belief in their ability to solve problems influences the emotions they experience during encounters in the mental health care setting.

ii) Attentional deployment

Attentional deployment refers to redirecting attention when one is in a situation to influence the emotional response (Gross, 2007). This is when the individual selects from active ‘internal situations’ in order to redirect attention from a painful situation by using distraction. Distraction is an important means of coping in the mental health care environment, as it enables the student to change the internal focus when experiencing distressing memories of events or situations.

iii) Cognitive change

Cognitive change refers to changing how one appraises a situation by altering its emotional significance. This may be referred to as reappraisal of the event (Lazarus, 1993). For example, students encounter many patients with different life circumstances which may have contributed to their mental illness. In some instances patients may refuse to talk about their personal history when students are conducting

an assessment. The students may interpret this as being directed at themselves and their perceived incompetence. Reappraisal or cognitive change of the situation may be that it is too distressing or insignificant for the patient to talk about. The interpretation of the situation whether it is correct or incorrect, may change the intensity (how much emotion) and quality (which emotion) of the students' emotional response.

iv) Response modulation

Response modulation refers to influencing physiological, experiential or behavioural responses directly (Gross & Thompson, 2007). In mental health care settings, this involves the student suppressing anxiety when confronted with mentally ill patients and taking control of the situation in order to cope with the experience.

## **2.6 EMOTIONAL SUPPORT**

Emotional support is the perception that there are individuals who share thoughts and feelings, thereby giving the recipient a feeling of being cared for and being loved. It boosts the student nurses' self-esteem by, for example, affirmation such as positive feedback. It is non-tangible and deemed important in maintaining the mental wellbeing of the student nurse (Payne & Walker, 1996). In mental health care settings, the positive attitudes of nurses towards students can assist in them feeling cared for and loved.

If support is perceived to be present it is viewed positively and if felt to be absent, a negative view is elicited. Student nurses and others – i.e. educators, clinical staff amongst others - need to have clarity on what support means to them. If both parties have a common understanding of what is deemed to be supportive - then the objective of caring, feeling loved and promoting emotional wellbeing will be achieved for the student nurse (Barre & Evans, 2004).

Affirmation support is a type of emotional support that is defined by others, for example education and clinical staff, as acknowledging that the student nurse may feel stressed whilst working in a mental health care setting. It purports that the student nurse is not alone nor different and prevents the feelings of isolation as others too have experienced the same emotions (Payne & Walker, 1996).

The aim of emotional support within the context of the educational clinical environment is, among other, to empower students towards self-reliance for own emotional wellbeing. Emotional support that raises a person's self-esteem and self-efficacy ("I can do it") is usually most effective in increasing self-awareness which is important in the therapeutic use of self by the student nurse in mental health care settings (Frisch & Frisch, 2011).

## **2.7 STRESS, EMOTION AND COPING**

There is a correlation between stress and emotion; stress always triggers emotion. Stress gives rise to emotional consequences whilst emotions contain all the phenomena of stress (Lazarus & Cohen-Charash, 2001). Stress is defined as a highly individualised process whereby a distressing psychological and/or physiological response is evoked by events which are significant for the individual (Stanley & Burrows, 2001). The term stress refers to the response rather than the conditions which evoked the stress. In the mental health care setting students would refer to stress as their subjective response to the environment. Coping on the other hand refers to the cognitive and behavioural attempts made by students to manage the demands of the mental health care environment but are appraised as exceeding the resources they possess (Lazarus, 1993).

## **2.8 THEORIES OF STRESS AND COPING**

Krohne (2002) avows that theories that focus on stressors (external demands), coping resources and stress (bodily processes) are classified into 'systemic stress' based in physiology (Selye, 1976) and 'psychological stress' developed in cognitive psychology (Lazarus & Folkman, 1984).

The following theories/models of stress and coping have been selected for discussion, based on their relevance to the core concept of this study, to ascertain their suitability for meeting the objectives of this study.

- Response-based model of stress
- Stimulus-based model
- Cognitive Transactional model of stress-appraisal-coping

### **2.8.1 Response-based model of stress**

Krohne (2002) maintains that response-based models of stress have a physiology and psychobiology base. An early proponent of a response-based approach to stress is Hans Selye. According to van Vuuren (2012), Selye, an endocrinologist, coined the term stress. This came about principally in response to the experiments performed on animals. An observation from the experiments concluded that stimulus events such as heat, cold and toxic agents - if applied intensely produced common effects. Selye proposed that a similar physiological response would result from the release of corticosteroids. These ideas were developed into a theoretical model called the general adaptation syndrome (GAS). Selye described stress as a syndrome consisting of non-specific responses to any demand made upon the body. This syndrome became known as the 'fight or flight syndrome'. GAS had three phases, viz. (a) the alarm reaction comprising of initial shock and counter-shock. The shock phase presents with autonomic excitability, increased adrenaline discharge and

gastro-intestinal ulceration. The counter-shock included defensive processes and increased adrenocortical activity; (b) if noxious stimulation increases, the stage of resistance occurs. Resistance to the noxious stimulus occurs but adaptation to other stressors decline; (c) if stimulation persists, the stage of exhaustion occurs. The organism's ability to adapt to the stressor is exhausted and the symptoms of stage (a) reappear but resistance is no longer possible and the organism dies if the stimulation persists

#### **2.8.1.1 Criticisms of Seyle's GAS**

Whilst the account of stress explained a number of important physiological processes in the development of stress-related illnesses, individual differences are unexplained. Some people do not become ill although they lead perceived stressful lives.

The GAS does not inform about the psychological components of stress although it alludes to the need for physiological homeostasis amid psychological processes (Krohne, 2002; Payne & Walker, 1996).

Coping mechanisms as a mediator in the stress-outcome relationship is unaccounted for.

Based on the above criticisms, GAS does not address the research objectives because neither psychological stress responses nor coping mechanisms are addressed and was therefore deemed unsuitable for this study.

#### **2.8.2 A stimulus-based model of stress**

Stimulus-based models of stress are derivatives of response-based models. Krohne (2002) refers to stress within the stimulus-based model being considered as something in the environment outside the individual. The focus is on stressors (stimuli) which provoke a stress reaction. All stress responses are not equally



important. Life events, positive or negative, are stressors. These stressors cause physical or psychological strain by taxing the adaptational capacity of individuals. Payne & Walker, (1996) avows that Holmes and Rahe developed the popular social readjustment rating scale (SRRS), to investigate their hypothesis that strain increased the possibly of developing health problems such as physical illness, anxiety and depression. They purported that all changes in life events meant that individuals would have to make some adaptations during their lives. They were not concerned whether the event was construed as negative or positive. The change was assumed to be stressful.

#### **2.8.2.1 Criticism of Holmes & Rahe SRRS**

The incidence of physical illness in a family may affect family members in different ways. The scores on the SRRS may be the result of many different stressors and therefore does not assist in identifying the type of support that needs to be given.

Psychological stimuli must be considered as factors causing strain but it is impossible to list stimuli that cause strain in all individuals. The coping ability of individuals is not identified in this model.

Based on the above discussion, the stimulus-based model of stress was deemed unsuitable because it fails to account for individual appraisals of the meaning of various life events - and therefore does not meet the objectives of the study.

#### **2.8.3 Theoretical framework selected for the study**

The cognitive transactional model of stress-appraisal-coping is explicated with reference to the process, limitations, strengths and suitability for this study.

#### **2.8.4 Cognitive transactional model of stress-appraisal-coping**

The cognitive transactional model of stress-appraisal-coping according to Lazarus & Folkman (1984), was selected for this study because it focuses on the processes of stress and coping, it also allows for the development of a framework for supportive strategies - and therefore meets the objectives of this study. The model is cognitive because it is based on the assumption that students' thinking processes, memory and the meaning that those events have for the student experiencing them - will act to mediate in determining stress and coping resources. Within the cognitive transactional model of stress-appraisal-coping by Lazarus & Folkman (1984) as depicted in Figure 1, the definition of stress emphasises the relationship between the student and the mental health care environment. Psychological stress refers to the 'relationship between the environment and the individual in which the individual appraises as significant for his or her wellbeing and in which demands tax or exceed available coping resources (Lazarus & Folkman, 1984:63). This implies that the stress experienced by students in the mental health care environment is deemed to be negative, since it has exceeded the students' ability to cope.

The model focuses on cognitive appraisal of stressors from the perspective of the person experiencing it and how the person copes within the stressful environment to make sense of the experience. The central assumption of this theory is that the interaction between an individual and the environment creates stress experienced by the individual.

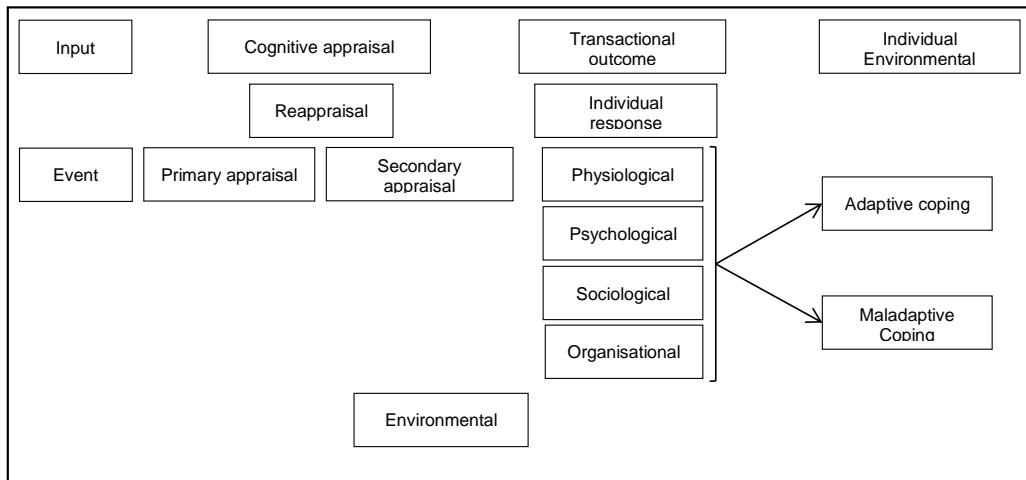


Fig. 2.1 Cognitive Transactional model of stress-appraisal-coping (Lazarus & Folkman, 1984)

The two processes which serve as mediators within this person-environment transaction are important. They are cognitive appraisal and coping. Cognitive appraisal is the students' evaluation of the personal significance of the event or the occurrence. This concept is necessary to explain how different students' emotional response in quality, intensity and duration differ in an equal objective environment such as the mental health care environment (Krohne, 2002). To determine whether or not coping or stress occurs, and its form, depends on each individual student's manner of construing (appraising) his or her relationship to environmental events. Appraisals are determined by personal and situational factors. Personal factors include motivational dispositions, goals, values and expectancies; situational factors refer to predictability, controllability and imminence of a potentially stressful event. The event elicits a response from the student and the response is influenced by how the student perceives the event (Lazarus & Folkman, 1984).

Cognitive appraisal consists of three forms of appraisal, namely – primary appraisal, secondary appraisal and reappraisal. These forms of appraisal, by definition, appear to imply that they involve deliberate conscious processing. However, according to Lazarus (1991,169) this is not the case because there are “two kinds of appraisal

processes - one that operates automatically without awareness or volitional control and another one that is conscious, deliberate and volitional". Primary appraisal refers to when the student assesses the challenge or the demand made by the situation. If the student receives support at this stage it may influence the interpretation of the event and promote a clearer understanding of the stressor (adaptive). Three components are distinguished within primary appraisal. Goal relevance is the extent to which the encounter refers to issues about which the person cares. Goal congruence defines the extent to which the event is aligned with personal goals. Type of ego involvement includes aspects of personal commitment such as self-esteem, moral values, ego-ideal or ego-identity. Secondary appraisal refers to the student's estimation of his/her ability to cope or his/her 'counter-harm' resources. Three components of secondary appraisal are identified. Accountability (blame or credit) refers to the individual's appraisal of who is responsible for the event. This implies that the student assesses who is to blame for the event. In a scenario where a patient may be physically violent towards the student, he/she may construe this to be in reaction to something he/she (student) said or did. Otherwise the student may assign blame to the patient for the behaviour as he/she acted in what is perceived as a caring manner but the patient responded negatively. Coping potential refers to the individual's evaluation of generating behavioural and cognitive mechanisms that will positively influence a personally relevant encounter. The student assesses his/her ability of dealing with the event by using thought processes or behaviours such as calmly walking away from the stressful encounter. Future expectancy refers to how the future of the event is predicted with respect to goal congruence or incongruence (Lazarus and Folkman, 1984).

Specific types of primary appraisal include events being evaluated as being irrelevant, benign-positive and stressful. When the event holds no significance for the

individual then it is referred to as irrelevant. A benign-positive appraisal occurs when the event produces a perceived pleasurable outcome. Stress appraisals are categorised as harm/loss, threat or challenge. Harm/loss appraisal refers to the damage or loss already experienced by the individual. The appraisal is 'threatening' when anticipated harm or losses are perceived. This implies that the student may perceive a mentally ill patient approaching him/her as someone who is going to attack. The event is then evaluated as being threatening to the student's person. Challenging appraisals refers to when the event is perceived to be challenging, here the individual focuses on the potential for growth rather than the risks associated with the event. Challenges also produce stress despite the associated emotions being perceived as positive. The individual then uses coping mechanisms to confront the new encounter (Lazarus & Folkman, 1984).

A secondary appraisal is made by the individual in response to the harm/loss, threat or challenge appraisal. Secondary appraisal refers to the assessment of skills, resources and knowledge that the individual possesses to deal with the encounter. This evaluation is based on consideration of the following factors:

- What coping strategies are available to me?
- Will the option I choose be effective in this situation?
- Do I have the ability to use the strategy in an effective manner?

The adaption response is determined by the primary appraisal of the event and the secondary appraisal of available coping strategies. Cognitive appraisal is context-based because what is perceived as stressful by one student may be perceived as challenging by another. Nonetheless, it is important for students so that they are able to discern between situations which are benign or dangerous. Physiological, psychological, sociological and organizational factors are taken into account when the student appraises the mental health care setting as benign or threatening

(Lazarus & Folkman, 1984). These factors may emanate from real experiences, personal background and student personality characteristics among others. Contingent on the various emotional responses, coping becomes relevant and specific to the encounter.

Coping is “on-going cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus, 1993:237). Coping is seen as a process which changes over time depending on the situational context (Lazarus, 1993). The term coping is used to refer to either adaptive or maladaptive coping. Thus, whether the coping process is perceived as good or bad depends on the student, the specific type of encounter and the mode of outcome. According to Lazarus (1993) there are no universally good or bad coping processes, although some may be better or worse than others in adaptational terms. Some coping strategies are stable and consistent over encounters, hence implying that the student uses the same coping strategies to deal with specific events if they are perceived as having been effective previously.

The process of coping has two major coping functions, namely problem-focused and emotion-focused coping. Problem-focused coping changes the person-environment relationship by acting either on the environment or the person. The students’ belief in their ability to solve problems influences the emotions they experience during the encounter. The function of emotion-focused coping is to either change the way the stressful environment is attended to or to change the relational meaning of what is happening without changing the actual conditions of the relationship. The students’ belief in their ability to handle the situation psychologically or that the situation must be tolerated influences the emotions they experience in the encounter (Smith & Kirby, 2009; Lazarus, 1993).

In order to clarify the transactional model in mental health care settings, an example is given below.

Individual in transaction: student nurse

Behaviour setting: Admission unit in a psychiatric hospital

Environmental demand: Mentally ill patient verbally abusing the student

Primary appraisal (how significant is the threat): The student assesses the demand to be the patient's response to being admitted against his will, thus the verbal abuse is not directed at her but rather at the circumstances from which it has emanated. This means that the student may offer a rational explanation for the patient's behaviour, i.e. the anger is projected.

*Secondary appraisal* (coping): The student overcomes the initial anger and bases coping on the fact that the patient is mentally ill. The student firmly states that verbal abuse will not be tolerated.

*Reappraisal* (how effective was coping): The student waits for the patient to respond; the patient apologises for the verbal abuse. The nurse then decides that a firm approach is an effective coping strategy.

#### **2.8.4.1 Criticism of the Cognitive Transactional model of stress-appraisal-coping**

The processes of primary appraisal, secondary appraisal and reappraisal appear to be protracted (Marsella & Gratch, 2009).

The rapid and autonomic associative processes involved in appraisal are difficult to study in detail (Marsella & Gratch, 2009).

There is greater focus on psychological factors which means that less emphasis is placed on physiological elements of the stress response which occurs during a stressful event.

The above criticisms do not have any effect on the use of the theory in the study for the following reasons:

This study does not seek to research the almost instantaneous process of the appraisal but rather that cognisance is taken of the process for the purpose of developing a model of emotional support for student nurses working in mental health settings.

The researcher by using inductive analysis was able to educe the physiological responses of the students in reaction to the stressful environment because although the main focus of the study was on eliciting students' psychological responses, physiological responses do occur during stressful encounters.

#### **2.8.4.2 Strengths of the transactional model of stress**

Both the mental processes and emotions are taken into account when examining how individuals interpret a situation as being stressful or not.

It provides a framework for strategies which can assist individuals when faced with threat or harm.

The perceived source of threat can be identified and coping strategies can be formulated.

The relationship between the threat and the coping strategy can be made clear, and consequently the individual would be able to gain personal control over the threat or the demands of the physical and social environment.

To develop a range of coping strategies

To evaluate the efficacy of the coping strategies that are used.

Theoretically the model accounts for individual variances in stress and coping strategies.



**Application of the Cognitive Transactional model of stress-appraisal-coping in guiding the data collection and data analysis process in the study.**

The Cognitive Transactional model of stress-appraisal-coping guided the development of the research questions, data collection and data analysis process.

The questions stated were:

- i) Tell me about your experiences of working in the mental health care settings?

This was to determine how students experienced working in mental health care settings and how they made sense of the experience. The emotional challenges were determined during the transactional encounter (input/event) between the student and the mental health care environment and according to the perception of the educators and clinical staff. These included the organisational, sociological, physiological and psychological responses which were elicited to explore and describe what had transpired during the appraisal network (i.e. primary appraisal, secondary appraisal and reappraisal).

The transactional outcome refers to how the students' responses in terms of organisational, sociological, physiological and psychological aspects within the mental health care environment were elicited and grouped after data collection. Perceptions of how educators and clinical staff perceive student coping were categorised for organisational, sociological and psychological aspects.

- ii) How do students, education and clinical staff perceive students coping in the mental health care setting?

*Individual-environmental consequences of the transaction* were related to how students coped within the environment - whether it was perceived to be adaptive

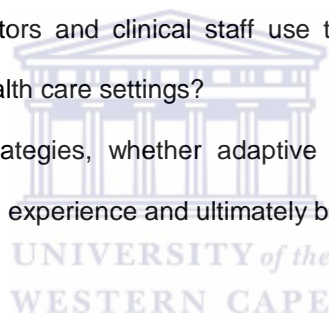
(effective coping) or maladaptive (ineffective coping) – as perceived by the students, educators and clinical staff, as well as identifying the support they utilised in order for them to cope.

- iii) What emotional support do students propose they need in a mental health care environment?

This question related to support needs identified by students, educators and clinical staff which would assist students to cope with the challenges experienced in the mental health care environment.

- iv) What strategies do educators and clinical staff use to support students while working in mental health care settings?

This question related to coping strategies, whether adaptive or maladaptive, to enable students to make sense of the experience and ultimately become self-reliant.



## **2.9 SUMMARY**

Three stress and coping theories - namely response-based, stimulus-based and the transactional model of stress and coping - were identified based on their reputation in the stress and coping research area. These theories were assessed for suitability for this study. Based on their focus, strengths and limitations of the response-based and stimulus-based theories they were deemed unsuitable to meet the objectives of this study. The transactional model of stress-appraisal-coping was selected to guide the exploration and description of the students' experiences in the mental health care environment based on the processes, strengths and limitations.

Chapter 3 focuses on the research methodology.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1 INTRODUCTION**

The objective of the study was to identify the emotional challenges experienced by students, to describe the emotional support needs of students, explore the educators and clinical staff's perception of how students were coping, to describe the strategies which educators and clinical staff use to support students as well as develop a model of emotional support for students working in mental health care settings.

This chapter describes the methods used in the study to achieve the above objectives. Research methodology is a coherent group of methods, - namely steps, tools and procedures, that will deliver data and findings to answer the research question and suit the research purpose (Henning et al, 2004). Research methods are the systematic, methodical and accurate execution of the design (Babbie & Mouton, 2001). A research design is a plan or blueprint for conducting a study (LoBiondo-Wood & Haber, 2010).

#### **3.2 RESEARCH APPROACH**

A qualitative research approach was adopted for this study. Qualitative research is concerned with a subjective exploration of reality from the perspective of the person experiencing the phenomenon (Fouche & Schurink, 2011). It is based on a naturalistic inquiry which implies that the experiences of the participants and their interpretation thereof will be studied in a natural state (Patton, 2002). A researcher using the qualitative approach and methods - is able to explain the relationships between the social, cultural, political and physical environments as well as that of the

individual by analysis of the stories they tell (Parse, 2001). The researcher sought the subjective accounts of the meaning that participants placed on the experience within the mental health care setting. Appraisals (interpretations) were recognised for their individuality, as the qualitative view of stress and coping allows for individual students to feel the same or different in objectively identical situations. In qualitative research, the researcher is the key instrument in the data collection process. The researcher gathered the data; the researcher delved in-depth into the complexities and the process of the participants' experience (Creswell, 2009).

This approach was therefore appropriate for this study because the researcher intended to explore and describe the experiences of students working in mental health settings namely the emotional challenges experienced, how students coped and the emotional support needs of student nurses within a mental health care environment, as well as the perceived coping and the strategies which educators and clinical staff utilise to support student nurses in these settings. The value of using a qualitative approach in this study is that the qualities and the characteristics or properties of students' experiences can be examined without placing boundaries on the experience (Henning et al, 2004). It is acknowledged that students are social beings and therefore as suggested by Parse (2001), their personal lives might have a relational influence on their experience within the mental health care setting. This implies that the participants exist in relation to others and therefore their experiences may be influenced by their personal lives. The researcher was therefore interested in obtaining the view participants hold about working with mentally ill patients (Creswell, 2009).

A non-mathematical process of interpretation, carried out for the purpose of discovering emerging concepts and relationships in raw data, was utilised to identify

concepts that were used in the emotional support model for student nurses working in mental health care settings in the Western Cape.

### **3.3 RESEARCH DESIGN**

An exploratory descriptive theory generating design was used in this study.

#### **3.3.1 Exploratory**

Exploratory research arises out of the lack of information about a phenomenon or to become acquainted with a situation in order to formulate a problem or to develop a hypothesis (Blaikie, 2000). Exploratory research is aimed at exploring the full nature of the phenomenon, the manner in which it manifested and its underlying processes (Polit & Beck, 2008). The answer to the “what” question constitutes exploratory research (Mouton, 2001). An exploratory design was used to gain insight and comprehension about the experiences of the participants in the mental health care settings (Fouche & De Vos, 2011). It was also used to explicate the main concepts of the study which were analysed and used in the model development in the second step of the study. This design was therefore appropriate for this study because the researcher explored the experiences of student nurses working in mental health care settings as well as the educators and clinical staff’s perception of student coping strategies.

#### **3.3.2 Descriptive research**

Descriptive research is designed to provide a complete and accurate description of a particular situation, social setting or relationship. An accurate description of the phenomenon is given by asking the “how” and “why” questions (Fouche & De Vos, 2011). The purpose of descriptive research is to provide a picture of a situation as it

naturally happens (Burns & Grove, 2003). This design was therefore appropriate for this study as a description and deeper meaning could be given regarding the emotional challenges that the students experienced in the mental health care settings. Student coping as perceived by educators and clinical staff was also described.

### **3.3.3 Theory generation**

Theory generative design is research that clarifies and describes relationships without imposing any preconceived ideas. Watson, (1985) states that theory is the grouping of knowledge, ideas and experiences presented symbolically to illuminate a phenomenon. Theory explains how concepts are connected (relationship) and gives an explanation of why things happen the way they do. The explanation of how things are is referred to as creating conceptual meaning. Conceptual meaning emanates from the students' thoughts which are described in words (concepts). This means that ideas and thoughts are used to represent experiences; included were differentiating between concepts which seem to be related and staying focused. Conceptual meaning is a mental picture of the nature of concepts or the phenomenon, and how it is perceived in human experience. It helps to delimit boundaries which provide direction in a study (Chinn & Kramer, 2004). If a student, for example, tells a peer that he/she is emotionally supportive then the peer begins to form an awareness of the self. This description may contribute to positive self-awareness depending on how the peer experiences the world. The purpose of theory is to enhance the understanding of the phenomenon (emotional support) but is presented as a model in this study as it will not be tested rather critically appraised. Models are visual representations of theory (Chinn & Kramer, 2004) and thus this approach was deemed suitable for this study, as the researcher envisaged developing an emotional support model for

student nurses based on empirical data obtained from the field and a review of the relevant literature.

### **3.3.3.1 Elements of theory building**

The three basic elements of theory building include concepts, statements and theory. The three basic approaches for working with these elements are synthesis, statements and analysis (Walker & Avant, 2005).

- **Concepts**

Concepts - the basic building blocks of theory as cited by Hardy, (1974) in Walker & Avant, (2005) - are mental formulations of experience. Experience is our perception of the world. The meaning of a concept is formed by: (1) the word; (2) the event; (3) feelings, values and attitudes associated with the word, and the event (Chinn & Kramer, 2004). Concepts are communicated through language and experiences and are classified in a meaningful way to make sense to the self and others (Walker & Avant, 2005). Concepts emerged during the process of qualitative content analysis whereby categories and themes were identified and concepts were elicited from themes. Concepts which were similar were grouped and these formed the main concepts. The main concepts were conceptually defined by means of both dictionary and discipline specific definitions. The foundation for developing an emotional support model for student nurses in mental health care settings was provided by these concepts.

- **Statements**

A statement is the expression of a relationship between two or more concepts. There are two forms of statements in theory building, namely: relational and non-relational statements. Relational statements declare a relationship between two or more concepts. The relational statements also describe the nature of interactions between

the concepts of the theory. Non-relational statements declare the existence of the concept or a theoretical or operational definition. Theoretical and operational definitions are important in theory building as they allow for testing and validation of theory in the “real world” (Walker & Avant, 2005; Chinn & Kramer, 2004). Relational statements were developed by looking at how concepts that emerged from the data were related or dissimilar. They thus clarified the relationship between and among the concepts in order to develop a graphical representation known as a model.

- **Theories**

A theory is a collection of relational statements that present a systematic view of a phenomenon by means of description, explanation, prescription or control. A set of definitions may be associated with the theory to enable a construal of the theory. This study sought to develop a model rather than a theory about emotional support as testing thereof was beyond the scope of the study. The graphic representation of a theory is called a model (Walker & Avant, 2005). A model for emotional support was developed to assist in supporting student nurses working in mental health care settings by identifying concepts during content analysis. The relationship between two or more concepts was identified and related statements which clarified the type of relationship were formulated. A model was illustrated which showed how the concepts were related.

### **3.3.3.2 Approaches to theory building**

The process of building theory or model development in this study is iterative and therefore the theorist may move back and forth among the approaches of synthesis, derivation and analysis. These approaches are interrelated and thus no single approach will meet all the needs for successful theory building (Walker & Avant,



2005). These authors, however, caution against using all these approaches together and suggest using only one strategy until it is no longer of any use.

- **Synthesis**

The concepts that emerged during the data analysis were developed (identified and described) by concept synthesis. Concept synthesis is a strategy that uses different forms of empirical evidence as a basis for the development of concepts (Walker & Avant, 2005). Synthesis means combining concepts to form a complex whole. Concept synthesis always begins with raw data which was obtained in this study from participants during focus group and semi-structured interviews. Large amounts of data were collected in the hope of sifting out important factors and relationships (Walker & Avant, 2005). This strategy was used to generate new ideas and insights which enhanced the development of the theoretical model.

- **Derivation**

Theory derivation procedures assist in structurally representing the relationships with concepts. Through the process of derivation, a theorist may redefine a concept, statement or theory from one context to another. This means that the researcher may take a concept such as emotional support from human science and by use of analogy describe how emotional support is construed by telemarketers employed in rural areas. This is usually applied in areas where no theory base exists (Walker & Avant, 2005).

- **Analysis**

The theorist is able to dissect a whole into its component parts for a better understanding using analysis as cited by Bloom (1956) in Walker & Avant, (2005). Clarification, refinement and sharpening of concepts, statements and theories occur during analysis.

In this study the elements of theory used in the development of the model were concept synthesis, statement synthesis and theory synthesis. Concept, statement, theory, analysis and derivation were not used in this study as concepts were not analysed but rather emerged from the data inductively. As there is an existing theory base for stress and coping it was not necessary to use the derivation approach (see Table 3.1).

Table 3.1: Model development processes (Walker & Avant, 2005; Chinn & Kramer, 2004) adapted from Bruce & Klopper (2010).

	<b>Avant &amp; Walker (2005)</b>	<b>Chinn &amp; Kramer (2004)</b>	<b>Model development processes used in this study</b>
Concept development	Concept analysis, synthesis, derivation	Creating conceptual meaning	Concept synthesis - to develop (identify and describe) concepts from empirical evidence, - interview data collected for study
Statement development	Statement analysis, synthesis, derivation	Generating and testing relationships	Statement synthesis - to specify relationships between the concepts developed.
Theory/model development	Theory analysis, synthesis, derivation	Application of theory	Theory synthesis - to express new insights into the phenomenon and present a model.

The process of model development as alluded to in Table 3.1 was conducted according to the four steps of theory generation as proposed by Walker and Avant (2005); Chinn and Kramer (2004; and Dickoff et al. (1968). These steps are as follows: These refer to concept synthesis, statement synthesis and theory synthesis (presented as a model).

STEP ONE: Concept identification

STEP TWO: Model development

Classification and definition of concepts (concept synthesis)

Statement development (statement synthesis)

STEP THREE: Model description

STEP FOUR: Guidelines to operationalize the model

### **3.4 STEP ONE: CONCEPT IDENTIFICATION**

The purpose of concept identification was to formulate conceptual ideas towards the development of a model.

#### **3.4.1 Concept Identification**

Concept identification took place by means of an exploration and description of student nurses' experience of working in mental health care settings. Focus group and semi-structured interviews were conducted. This process is described below.

#### **3.4.2 Research population and sampling**

##### **Study population**

A study population is "all the potential individuals who possess specific characteristics in which the researcher is interested" (De Vos 2011:223). The study population comprised of all the nursing degree students that were registered for fourth year psychiatric nursing modules at the school of nursing in 2011. Educators at the HEI who teach and supervise nursing students in psychiatric nursing and all the clinical staff, working at the psychiatric hospitals and community mental health clinics where students are placed to meet the SANC requirement for psychiatric clinical hours, were included. The population included a total of 246 students that

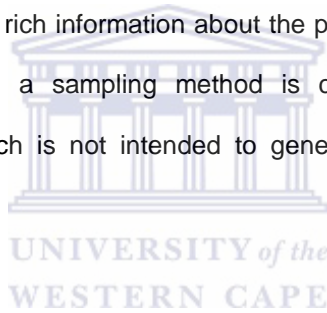
were registered for fourth year psychiatric modules in 2011 at the University of the Western Cape and ten educators, who were comprised of three lecturers and seven clinical supervisors who teach psychiatric nursing science and supervise undergraduate mental health nursing students. The clinical staff included all the registered nurses who work in the four psychiatric hospitals and community mental health clinics.

The target population was student nurses (n=246) studying towards Bachelor's degrees in Nursing at the University of the Western Cape. These students were all in their fourth year of study. They were all engaged in the psychiatric component of the nursing programme. Clinical placement of these students included placement in three psychiatric hospitals, a hospital for intellectual disability and community mental health clinics. The patients in these settings presented with a range of mental illnesses with various levels of severity. This meant that the student nurse would for example be exposed to the psychotic patient in a psychiatric hospital or community mental health clinic, or to patients who are mentally stable but receiving chronic psychotropic medication. All the students were exposed to these types of patients and clinical placements, as the clinical placement varied from three to four weeks per placement rotation. The students worked a total of 24 hours (three days) per week in the clinical setting. They spent the other two days in class at the university receiving tuition on mental health nursing, professional practice and research methodology. The students worked in the various mental health care settings from February to November during the fourth year of the nursing programme. At the end of the fourth year the total clinical hours in the mental health care setting added up to 880 hours.

## **Sampling strategy**

Sampling is the process of selecting a portion of the population (people, events and behaviour) to represent the entire population. A sample is a small portion of the population that is selected for a particular study (Burns & Grove, 2003).

Purposive sampling was used to select the participants for the study. Purposive sampling is a type of non-probability sampling which is based on the judgement of the researcher to select a sample that contains the most characteristic, representative attributes of the population that serves the study population best (Grinnell & Unrau, 2008). The use of purposive sampling allowed the researcher to use her knowledge and expertise regarding the study population to select participants who yielded insights and rich information about the purpose of the study (Brink, 2007). The choice of such a sampling method is consistent with the exploratory nature of the study which is not intended to generalise toward large populations.



Since three research population groups namely students, educators and clinical staff, were included in the study, the sampling was implemented as follows:

- **Students**

Participants were recruited by means of an announcement regarding the study to the students in class. The aim thereof was to inform the students of the purpose and objectives of the study, and to request volunteers based on the inclusion criteria (see overleaf for inclusion criteria) and the information in the Participant Information Sheet (Appendix 10). The clinical supervisors and clinical staff were also approached and invited to identify students who met the inclusion criteria. The researcher handed-out a list in class and volunteer participants provided their names and contact details. Fifty-two (52) students volunteered to participate in the study. As the students were

working in the mental health care setting at the time of data collection, the researcher obtained a placement list from the student administrator which showed where the students were working. The researcher then contacted each student individually; a time, date and venue were arranged to meet with the students.

Brink (2007) cautions against selecting too many participants as the issues may be clouded and the complexity of the analysis may be increased. A total of 40 students who met the inclusion criteria finally participated in six focus group discussions. This was largely because some students who had initially volunteered to participate in the study did not turn up for the focus group discussions.

Inclusion criteria refer to the criteria that specify population characteristics (Polit & Hungler, 1999). The criteria for inclusion in this study were students who had to:

- be registered as a fourth year nursing students at UWC and with SANC in 2011;
- be placed in a mental health care setting for clinical practice;
- be able to communicate in English;
- have volunteered to participate in the study.

### **Description of the demographics of the student participants**

A total of 40 students participated in the focus group discussions. The participants' ages varied between 21 and 46, with the average age being 27 years. Most (n=31) students were between the ages of 21 and 29, six students were between the ages of 30 and 39, whilst three students were between the ages of 44 and 46. Most (n=22) of the participants were Black, 15 were Coloured, two White and one Chinese. Females accounted for most of the participants (n=30) whilst there were ten males.

### **Educators**

The participants were recruited by means of an announcement regarding the purpose and objectives of the study at a meeting. This meeting was attended by

educators who were teaching and supervising mental health nursing students at the participating university. These educators were recognised as key informants with reference to their teaching experience in mental health nursing. One lecturer was the co-researcher during the focus group interviews with the students and was thus excluded from the study to prevent bias. One clinical supervisor was newly appointed and had therefore not supervised the student sample; she was thus excluded. Lecturers and clinical supervisors who met the inclusion criteria were invited to participate in the study. This was based on the inclusion criteria and the information on the Participant Information Sheet (Appendix 10). Two lecturers and six clinical supervisors volunteered to participate in the study and were individually interviewed.

Criteria for inclusion were as follows – they had to:

- be employed at the participating higher education institution
- be voluntary participants
- teach psychiatric nursing science modules to fourth year students registered at UWC; or
- be clinical supervisors employed by the University of the Western Cape to supervise mental health nursing students at the psychiatric hospitals in the Western Cape.

#### **Description of the demographics of the educator participants**

The participants' ages varied between 28 and 52, with the average age being 41 years. Most (n=4) of the participants were Black, two were Coloured, one White and one Indian. Females accounted for most of the participants (n=6) whilst there were two males. The teaching experience of the participants ranged between three and 27 years, with the average amount being 12 years.

### **Clinical staff**

The total clinical staff sample of nine consisted of two registered nurses at each of the four psychiatric hospitals and one at a community mental health care clinic in the Western Cape Metropole region.

Of the sample, one of the registered nurses at a psychiatric hospital was the student placement coordinator. This person was selected because he/she was the individual responsible for dealing with all student matters at the various hospitals. The researcher asked both the student nurses and clinical supervisors to identify clinical staff that they deemed to be supportive. The nursing managers at the various mental health care settings identified participants who they deemed as being supportive of students. Students also identified two participants (included in the nine participants) who they deemed to be emotionally supportive. The participants were thus selected using purposive sampling to participate in the study. In addition, they had to meet the following inclusion criteria – they had to:

- be registered nurses employed at one of the four psychiatric hospitals; or
- be registered nurses employed at one of the community mental health clinics where students are placed for clinical practice;
- have volunteered to participate in the study; and
- be deemed as supportive by student nurses and educators (clinical supervisors).

### **Description of the demographics of the clinical staff participants**

The participants' ages varied between 36 and 64, with the average age being 47 years. Most (n=4) of the participants were Coloured, three were Black, one White and one Indian. Females accounted for most of the participants (n=7) whilst there were two males. The clinical experience of the participants ranged from four and 31 years with the average being 15 years.



**Table 3.2: Study participants**

Category	Total number of participants	Number of focus group interviews	Semi-structured interviews
Students	40	6	-
Educators: Lecturers	2	-	8
Clinical supervisors	6	-	
Clinical staff: Professional nurses	8	-	8
Community mental health nurse	1		1

### **3.4.3 Access to the site**

Access to the research setting was obtained from gatekeepers. The gatekeepers are people who control access to the site and the people within it (Green & Thorogood, 2009). In this study the formal gatekeepers were the Dean of Research for the HEI, the CEO's of the psychiatric hospitals, the Director of the Department of Health in the Western Cape and the relevant nursing managers. Formal written permission was obtained from the Dean of Research at the University of the Western Cape in order to obtain access to the student and educator participants (Appendix 2). Telephonic appointments were made with student groups and educators after permission was granted.

Permission for access to participants (clinical staff) working at the four psychiatric hospitals was obtained from the respective Chief Executive Officers (Appendices 3,4,5,6) of the hospitals. Permission was also obtained from the Director of the Department of Health of the Western Cape, for access to the two community mental health clinics (Appendix 7,8). Delays were experienced with obtaining the necessary permission as some officials were tardy in responding. At one hospital, the research proposal and ethical clearance letter had to be forwarded three times as it had been archived. A series of telephone calls ensued to elicit a response. The researcher was compelled to call on the hospital in person to communicate directly with the nursing

manager. Permission was then finally granted. The nursing service managers at the respective institutions informed the identified participants of the study and that participation therein was voluntary. All the identified participants agreed to participate in the study. The researcher arranged appointments telephonically with the clinical staff - to meet at a time, date and venue most suitable for them.

#### **3.4.4 Pilot study for focus group interviews**

Bless, Higson-Smith and Kagee (2006:184) states that a pilot study is “A small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate”. Prior to the focus group interviews, a pilot study was conducted with four female student volunteers. This was conducted in an office at the HEI. The pilot study was facilitated by both the researcher and an experienced researcher. The purpose thereof was to test the interview schedule (appendix 13) questionnaire in order to ensure that the questions were clear and that they responded to the research aim. Changes which were affected to the interview schedule after the pilot study included using specific probes (such as what was negative about your experience) to elicit the emotional challenges experienced by the students based on the feedback from the participants and the researchers.

#### **3.4.5 Data Collection Methods**

A combination of data collection methods were used. These included focus group (students) and semi-structured individual (educators and clinical staff) interviews for the purpose of obtaining the relevant research data.

Data collection commenced mid-October 2011 and was completed in April 2012.

### **3.4.5.1 Data collection: Focus group interviews**

- **Focus group interviews**

A focus group interview is a 'purposive discussion of a specific topic or related topics taking place between eight to ten individuals with a similar background and common interests' (Schurink, Schurink & Poggenpoel, 2001:314). The choice of focus group interviews as a data collection method was based on the fact that all participants were employed in mental health care settings. It was envisaged that they would be able to contribute to the understanding of the student nurses' experience in mental health care settings (Schurink, et al, 2001). Multiple viewpoints and self-disclosure about the students' experiences of working in mental health care settings and their perceived needs were sought. Focus group interviews were therefore deemed to be the most appropriate method of obtaining the information (Greeff, 2011).

The focus group interviews for the student participants were held at the four psychiatric hospitals, since they were working in the clinical setting at the time of the study. Permission to use venues on site was obtained from the hospital managers after the students who had volunteered to participate in the study had been identified. Focus group interviews were conducted during October and November 2011. This time frame was selected as the students were completing the nursing programme at the end of 2011. This meant that all students would have completed more than 90% of the psychiatric nursing clinical hours.

A total of six (6) focus group interviews were conducted. One pilot focus group interview was conducted; two focus group interviews were conducted at one psychiatric hospital and one focus group interview was conducted at each of the other three hospitals. Each group consisted of between five and nine participants. The groups constituted both male and female students.

The researcher acted as the moderator for all the focus group interviews. A colleague performed the role of co-moderator. His duty was to take detailed notes on the group dynamics and body language of the group. Prior to commencing the focus group interviews, the researcher would welcome all the participants and introduce the co-moderator and herself. Participants were encouraged to introduce themselves as they were not acquainted with everyone in the group. The researcher would then inform the group of the purpose of the study, in order to eliminate any assumptions about the nature of the study. Permission was obtained from the participants to audiotape the discussion. The participants were required to sign a voluntary participation (Appendix 11) and focus group confidentiality binding form prior to the commencement of the focus group discussion (Appendix 12).

All the participants were encouraged to participate fully in the group discussions. The participants were informed that there were no right or wrong answers and assured that all their contributions were valuable. Probing comments or questions were used to steer the discussions and to clarify aspects that were unclear to the researcher (Paton, 2002). Verbal prompts such as 'uh-huh', 'mm' and non-verbal cues such as head-nodding were used to encourage participants to continue talking. Elaboration probes such as 'and then what happened?' were used to encourage elaboration (Green & Thorogood, 2009).

At the end of focus group interviews, the researcher briefly summarised the main points of the interview and sought verification from the participants. All the participants were thanked for their participation at the end of the session (Nyamathi & Shuler, 1990).

- **Advantages of focus group interviews**

Focus groups have the ability to produce precise data on the topic under discussion. The group perspective of focus group interviews focuses on the active encouragement of group interaction between participants (Greeff, 2011; Webb & Kevern, 2001). The open-response format of focus groups provided an opportunity for the researcher to obtain data in the participants' own words (Bickman & Rog, 2009). Group synergy has the ability to obtain information that may be lost if the students were interviewed individually. The group also assists in uncovering the emotional processes that determine behaviour (Greeff, 2011).

- **Disadvantages of focus group interviews**

Focus groups require researchers who are skilled in group processes and are costly. If the group facilitator is unskilled, less talkative students' voices may not be heard over that of the more talkative students. Students may also feel the need to fit in and then their responses would be constrained (Greeff, 2011).



### **3.4.5.2 Data collection tool**

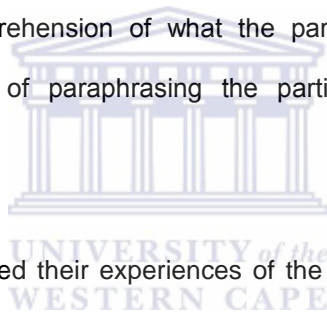
The development of the data collection tool was influenced by the Transactional model for stress-appraisal-coping (see 2.8.4). The objectives of the study guided the questions that were asked. A pilot study was conducted and changes were effected on the recommendations of the students. The data from the pilot study was included during the data analysis process.

The following broad research questions (Appendix 13) were asked at each focus group interview:

- Tell me about your experience of working in the mental health care settings?
- Tell me about your feelings in these specific incidents?
- How were you able to cope with the situations?

- What support do you think would you have needed to enable you to cope with the situation emotionally?

Probes were used to obtain data on “thin” areas (Greeff, 2011: 351) and to verify what the researcher heard was actually what the participants meant (Niewenhuis, 2007). There are three probing strategies which the researcher used whilst conducting the focus group and semi-structured interviews. Detail-oriented probes were utilized to ensure that the researcher understood the “who”, “where”, and “what” of the answers that were given by the participants. Elaboration probes were used to obtain a full picture of what the participants were saying and this was done by asking participants to “tell me more about it”. Clarification probes were used to check the accuracy of the researcher’s comprehension of what the participants had said. Clarification was done by means of paraphrasing the participants’ words for confirmation (Niewenhuis, 2007).



Most of the participants communicated their experiences of the mental health care settings in English (Appendix 16). However, three students interspersed the communication of their experiences with Afrikaans terms to express themselves more eloquently during the discussions. This transpired mainly when they expressed emotions, for example - ‘*ek het kwaad gevoel*’ [I felt angry]. In the Western Cape both Afrikaans and English languages are widely spoken; some of the students’ home language is Afrikaans. The other students nodded in acknowledgement during this Afrikaans-English communication, which indicated to the researcher that they understood what these participants were saying. The interview schedule (Appendix 13) was the same for all the focus groups.

### **3.4.5.3 Data collection: semi-structured interviews**

The educators and clinical staff were asked the same set of questions (appendices 14 and 15). The researcher chose this method of data collection, from the educators and clinical staff, as she needed to obtain a detailed picture of the participants' perceptions of student experiences in the mental health care setting. This was undertaken with the aim of obtaining information to find ways of supporting students emotionally in the mental health care setting. The assumption was that if the educators and clinical staff were cognisant of student experiences, then they would be able to offer suggestions on how to support them.

- **Purpose of semi-structured interviews**

An individual interview is an interaction between the researcher and the participants where the researcher has a general plan of inquiry but does not ask questions in a predetermined order thus allowing the participant to do most of the talking (Babbie & Mouton, 2001). In semi-structured interviews the researcher sets the agenda about topics to be covered and the participants' responses determine the kind of information produced by these topics (Green & Thorogood, 2009).

- **Advantages of semi-structured interviews**

The nature of the semi-structured interview allows the researcher and the participants more flexibility, it enables the researcher to follow up on interesting information that he/she had not thought of. Participants are inclined also share more easily if the interview takes this direction (Greef, 2011).

- **Disadvantages of semi-structured interviews**

It is easy for the researcher to become side-tracked during the interview with trivial issues (Niewenhuis, 2007).

Patton (1990) asserts that the quality of information obtained during the interview is dependent on the interviewer's skills and personality. If the interviewer is not skilled,

lacks knowledge of the participant's culture or frame of reference, very little useful data may be collected.

The researcher has 15 years of clinical experience as a community mental health nurse. A large part of the researcher's work included interviewing patients, families and communities in historically disadvantaged areas in the Cape Town metropole area. It is safe to avow that the researcher is skilled and conversant with the different cultural contexts of individuals – likewise of students, educators and clinical staff.

#### **3.4.5.4 Data collection tool**

The interviews were guided by a set of predetermined questions on an interview guide (see Appendix 14, 15). However, the interview was not limited to the questions. Both the educators and clinical staff were asked the following questions during the interview:

- What are the issues that you are aware of, do students have to cope with emotionally?
- What are the strategies that you use to assist them to cope?
- What existing support is in place to support students emotionally?
- What would you suggest that the SoN put in place to support students who work in mental health care settings?
- What would you suggest that the clinical services put in place to support students in this emotionally challenging environment?

#### **• Educators**

The individual interviews for educators were conducted between January and April 2012.



The researcher set up interview times and dates with the participants personally and confirmed the prearranged appointments telephonically a day before the event. The two lecturers (see clarification of terms) were interviewed in their respective offices. Green & Thorogood (2009:111) maintains that interviewees prefer to be interviewed in a private space that they feel is 'theirs'. As the clinical supervisors (see clarification of terms) did not have an office on the HEI, they were interviewed in an office close to that of the researcher. This was done to avoid interruptions. Prior to the interview, the researcher thanked the participants for volunteering to participate in the study and explained the aim of the study to them. The participants signed consent forms; permission was obtained from the participants to use a voice recorder to audiotape the interviews, which would be transcribed verbatim and used in data analysis. Audiotaping allows the researcher to maintain eye contact and to concentrate on how the interview is proceeding (Greeff, 2011). The researcher checked the audio recording after the interviews to ensure that the interviews were recorded. These were then labelled, dated and saved. The researcher made contextual and field notes immediately after the interviews were completed, whilst the events were still fresh in her mind.

#### • **Clinical staff**

The individual interviews for clinical staff were conducted between December 2011 and April 2012.

The researcher contacted the participants individually, to request voluntarily participation in the study after permission was obtained from the respective CEO's of the four psychiatric hospitals and the Head of the Provincial Department of Health for the two community mental health clinics. They had been informed of the study by the nursing managers. The aim of the study was explained to the participants, they then informed the researcher of suitable times, dates and venues for the interviews to take

place. These were all conducted at offices in the various institutions. Probes were also used in these participants' interviews.

### **3.4.6 Field Notes**

Field notes are the written accounts of what the researcher had experienced, heard and felt during the process of collecting and reflecting on the data (Bogdan & Biklen, 2007). Field notes were made after each focus group and individual interview. These included the seating arrangement, the order in which the participants spoke, non-verbal behaviours and striking themes (Greeff, 2011). Reflections on analysis, method, ethical dilemmas and the researcher's frame of mind were also included (Bogdan & Biklen, 2007). Field notes enhance the richness of the data gathered by creating a detailed record of all the occurrences during the interview (Holloway & Wheeler, 2002). The researcher and the co-moderator discussed the notes after each of the focus group interviews. These interpretative notes assisted in developing classifications in initial concepts synthesis (Walker & Avant, 2005).

The researcher also kept a reflective journal in which insights, thoughts and experiences were written after every interview - to elicit bias and prejudice as the researcher has been a mental health practitioner for 15 years and a mental health educator for the last five years.

### **3.4.7 Data Analysis**

Babbie (2007:378) avers that data analysis is the "nonnumerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships". The process of data analysis is to systematically generate, develop and verify concepts from transcribed data. Qualitative data

analysis uses the process of inductive reasoning. Inductive reasoning moves from concrete observations to a general theoretical explanation (Babbie, 2007).

The data analysis process was iterative as both analysis and interpretation took place simultaneously even though it will be presented as a step-by-step approach for simplification. Creswell (2007:150) alludes to this process as a 'data analysis spiral'. The aim of data analysis is to answer the research question of the study (Corbin & Strauss, 2008).

In this study, focus group interviews and semi-structured individual interviews were the primary sources of data for analysis.

#### **3.4.7.1 The inductive approach to qualitative data analysis**

A conventional approach to content analysis was used in this study, as the aim of this study was to describe a phenomenon (student experiences of working in mental health care settings) and to develop an emotional support model for student nurses (Hsieh & Shannon, 2005). In content analysis, the researcher avoids using preconceived categories. Categories and names for the categories are allowed to flow from the data. This is also called inductive category development as the researchers immerse themselves in the data to allow new insights to emerge (Kondracki & Wellman, 2002).

An inductive approach to data analysis was used. An inductive approach according to Patton (1990: 44) is "the extent that the researcher attempts to make sense of the situation without imposing pre-existing expectations on the phenomenon or setting under study".

### 3.4.7.2 The procedure of inductive analysis

The data from the focus group and individual interviews were analysed using Tesch's method of identifying themes in the data, which allows a structured organisation of data to take place (Creswell, 2003).

The steps included the following:

- All the transcriptions were carefully read repeatedly to achieve immersion and to get a sense of the whole.
- One transcription was read carefully line by line and exact words or phrases that appeared to capture key thoughts and concepts were highlighted.
- Notes of first impressions, thoughts and initial analysis were made in the margins of the text.
- This process was continued for several documents and a label for codes that reflected more than one key thought emerged.
- The Nvivo 8 software package was used to facilitate the process of storing, sorting and analysing the data. Data sources were stored in separate folders. The researcher coded numerous units of text from each data source.
- Codes were then sorted into categories depending on how the different codes were linked or related.
- The research questions were used under which the categories were clustered, to ensure that the research objectives were answered and to ascertain if data saturation had occurred.
- The number of clusters were between 10 and 15 to keep them broad enough to sort a large number of codes.
- Depending on the relationships between the subcategories, the researcher combined the subcategories into a smaller number of categories.
- Definitions were then developed for each code, subcategory and category.

- As coding and categorisation was taking place, the researcher made memo notes in the Nvivo programme to capture insights, ideas and thoughts for further analysis. This process aided with the interpretation of the data.
- Continuous refinement of categories occurred. Categories were combined or linked to form themes when the meanings were similar.

Different sets of themes emerged under each component of the Transactional model of stress-appraisal-coping for each participant group and these are presented in Chapter 4.

The researcher transcribed most of the interviews (Appendix 16, 17, 18) as this provided an opportunity to become immersed in the data. These were transcribed verbatim. Emergent insights that were generated during the process of transcribing were typed, labelled and stored in a file. These were utilised during data analysis. Some interviews were transcribed by an independent transcriber. These were checked for accuracy by the researcher - it involved listening to the audiotapes and making the necessary corrections. This process also aided the researcher to familiarise herself with the data.

A colleague acted as an independent coder to increase the trustworthiness of the data analysis process. The independent coder was a colleague who had a PhD qualification. He coordinated and taught on the Master's Programme in Advanced Mental Health at the SoN. He was familiar with the context, the research and theory of the study. Henning et al (2004) disproves of the use of an independent coder who had not been part of the research or who did not know the context. The same author further asserts that the term 'independence' stems from a positivistic paradigm. In this study the transcripts of the audiotaped interviews, the research objectives and a data analysis guide were given to the independent coder who then coded them independently. This was done to ensure trustworthiness of the coding data. The

researcher and the independent coder reviewed the data to make judgments and interpretations of the content and meaning of the material (Patton, 2002). Interpretation of the data was modified according to consensus discussions between the researcher, independent coder and the supervisor of the study.

Table 3.3 depicts a summary of step I of the methodology process. The table reflects the number of participants namely students, educators and clinical staff who participated in the study; the research questions asked; how the cognitive transactional model of stress-appraisal-coping informed the data analysis process and the data analysis reasoning strategies which were applied during data analysis.



Table 3.3: Summary of step 1 of the methodology process

Data sources / Collection method	Research question	Probes	Model	Data analysis
Students (n=40) Focus group interviews	What are the emotional challenges experienced by students working in mental health care settings?  What emotional support do students propose they need in a mental health care environment?	Tell me about your experience of working in the mental health care settings? (probe for specifics)  Tell me about your feelings in these specific incidents?  How were you able to cope with the situations?  What support do you think you would have needed to enable you to cope with the situation emotionally?	Event  Transactional outcome  Individual responses - Physiological - Psychological - Sociological - Organisational  Coping resources: Maladaptive Adaptive  Specific context HEI Clinical setting	Inductive analysis Synthesis
Educators (n=8) Individual interviews  Clinical staff (n=9) Individual interviews	How do education and clinical staff perceive students coping in the mental health care setting?  What strategies do education and clinical staff use to support students working in mental health care settings?	What are the issues that you are aware of, that students have to cope with emotionally?  What are the strategies that you use to assist them to cope?  -What existing support services are in place to support students emotionally?  -What would you suggest that the clinical services put in place, to support students in this emotionally challenging environment?  -What would you suggest that the SoN put in place, to support students who work in mental health care settings?	Event  Transactional outcome  Individual responses - Physiological - Psychological - Sociological - Organisational  Coping resources  Specific context HEI Clinical setting	Inductive analysis Synthesis

The findings which emerged from step 1 (concept identification) was utilised step 2 Model development (concept description and statement development), in step 3 (model description) and step 4 (guidelines to operationalize the model).

### **3.5 STEP TWO: MODEL DEVELOPMENT**

The process of model development includes concept description and statement development. Synthesis was used as the approach to model development because the concepts that emerged from step one needed to be connected theoretically. Synthesis assisted the researcher in the interpretation of the data (Walker & Avant, 2005).

#### **3.5.1 Step 2: Concept development (description)**

The concepts which were identified and described during the data analysis of the focus group and individual interviews were developed by means of synthesis. Concept synthesis is a strategy for developing concepts by means of different forms of empirical evidence (Walker & Avant, 2005). Concept synthesis begins with raw data which in this study was obtained from the focus group and individual interviews. There are three approaches to concept synthesis, namely: qualitative, quantitative and literary approaches. The qualitative and literary approaches to concept synthesis were found to be suitable in this case, as this study utilised a qualitative approach and literature control to assist in identifying similarities and differences in the data. A literary approach involves examining relevant literature for the purpose of acquiring new insights about the phenomena. Data classified into categories in step 1 were clustered. Clustering involved comparing each classification category with the other. This was done by the researcher and supervisor using visual inspection. Once the clusters were discovered, they were examined for hierarchical structure. Where two clusters appeared to be similar, they were combined to form a higher order concept. In order to classify the concepts, the researcher made use of the six vantage points of surveying activity together with the six aspects of activity as listed by Dickoff et al, (1968). These included:



Agency - *Who or what performs the activity?*

Patiency or recipiency - *Who or what is the recipient of the activity?*

Framework - *In what context is the activity performed?*

Terminus - *What is the end point of the activity?*

Procedure - *What is the guiding procedure, technique or protocol of the activity?*

Dynamics - *What is the energy source for the activity?*

These steps are aimed at the systematic ordering of the concepts and their related concepts. The survey list was used to identify the agent that carried out the strategies, who the recipients of the strategies were and the context in which they were carried out. The survey list also assisted the researcher to identify the dynamics required for the activities to take place, as well as the procedures which were required to guide them. The terminus or the end-point of the activity – is to ensure that students take responsibility for the fulfilment of their emotional needs whilst working in mental health care settings (chapter 5, table 5.2) depicts the concepts and the related classification according to the survey list).

The six concepts were defined by means of dictionary definitions and subject definitions which used their defining attributes to clarify the concepts in terms of their relevance to the study.

### **3.5.2 Statement development and synthesis**

The researcher employed statement synthesis to specify relationships between two or more concepts which were derived from the concept development stage and their relationship to the six elements of the survey list (Walker & Avant, 2005). Qualitative methods were used to make inferences from the data. Generalisation from specific

inferences to more abstract ones was facilitated by the literary method process. Only statements that were derived from or supported by empirical evidence were utilised in this study (Walker & Avant, 2005).

### **3.5.3 Step 3: Description of the model**

The following questions were asked in order to describe the theoretical model (see 5.5) that was developed for the emotional support of student nurses in mental health care settings:

- What is the purpose of this model?

This question is important as it specifies the context and situations to which the theory applies. The question can then be asked: Why was this model formulated?

- What are the concepts of this model?

This question identifies the ideas that are structured within the model. Concepts must be examined for quantity, character, emerging relationships and structure. This is important because their quantity and character form understanding about the purpose of the model.

- How are the concepts defined?

This question clarifies the meaning of the concepts within the model. Concepts may be defined explicitly or implicitly - thus it is important to ascertain if the definitions are consistent with implicit or explicit definitions. Can general language meanings be accepted as the intended meanings? Are the definitions general or specific?

- What is the nature of the relationships?

This question addresses how concepts are linked together. The theoretical purpose and the assumptions are ascertained from cues in the way that the relationships emerge.

- What is the structure of the model?

The structure of the theory gives overall form to the conceptual relationships within it.

- On what assumptions does the model build?

This addresses the basic truths taken to underlie theoretical reasoning. To uncover the assumptions, the question that needs to be asked is: What is the researcher taking as an accepted truth? (Chinn & Kramer, 2004).

#### **3.5.4 Step four: Guidelines to operationalize the model**

Deliberative application and validation involves using “empiric knowledge to guide practice and practice-oriented approaches that contribute to empiric knowledge development” (Chinn and Kramer, 2004:145). There were three sub-components in the deliberate application of the model which was used in this study, it included:

- Selecting the clinical setting – The clinical setting for deliberative application for this research was identified by the participants in step 1 of this study
- Determining outcomes variables for practice – The outcome variables for this study, ensured that an emotional support model for students in mental health care settings, met the emotional needs of the students with the aim of promoting responsibility for own emotional needs.
- The model that was developed was not implemented or tested in this study as this was beyond the scope of this study. Guidelines were developed to operationalize the model.

#### **3.6 MEASURES TO ENSURE TRUSTWORTHINESS**

Guba’s model for assessing trustworthiness was used in this study, as it is conceptually well-developed and used extensively in other studies. The four constructs that these authors propose are credibility, transferability, dependability and conformability.

- **Credibility**

Truth value asks whether the researcher has confidence in the truth of the findings of the participants and the context in which the study was undertaken (Guba, 1981). Credibility can be enhanced by prolonged engagement with the participants, triangulation of different methods, peer debriefing, member checks and formalised methods such as analytic induction (Lincoln & Guba, 1999). The researcher spent time in the field establishing a rapport with the participants. She spent time with the participants after the focus group discussions, as they wanted to discuss 'off the record' aspects. In this study, truth value was established by using multiple methods of data collection (i.e. focus group interviews and individual interviews). The credibility was enhanced by 'member checking' of the interview transcripts by educator and clinical staff participants, to ensure accurate transcription of the participants' views.

Triangulation of the different sources and data led to an enhanced trustworthiness of the study. The researcher used different participant groups - namely students, educators and clinical staff - to obtain a range of interpretations and meanings of the research aim. Data was collected by means of focus group and individual interviews. To further enhance credibility regarding referential adequacy, the researcher audiotaped all the interviews which were transcribed verbatim. The researcher also reviewed her perceptions, insights and analysis with a peer who understood the nature of the study. This process is referred to as peer debriefing (Babbie & Mouton, 2001).

- **Transferability**

Applicability is ensured by transferability which refers to the consistency at which the findings of the study can fit similar contexts outside the study (Lincoln & Guba, 1985). This was ensured by the presentation of a detailed description of the participants,

research context and setting together with appropriate quotations. It is however, the reader's decision whether the findings are transferrable to another context or not (Graneheim & Lundman, 2004).

In this study a description of the research methodology was provided in addition to an audit trail. The researcher also purposively selected the sample to maximise the range of information from and about the context. The locations were different psychiatric hospitals and the participants ranged from students to educators and clinical staff who had the common interest of working in mental health care settings.

- **Dependability**

Dependability “seeks means of taking into account both factors of instability and factors of phenomenal or design induced changes” (Lincoln & Guba, 1985: 299). Dependability refers to whether the findings would be consistent if the study were to be repeated with the same participants or within a similar context (Krefting, 1991). The research process must be logical, well-documented and audited (Schurink, Fouche & De Vos, 2011). The researcher kept an audit trail of the research process to enhance the dependability of the study. Independent verification of coding by an independent coder also enhanced the dependability of the study.

- **Confirmability**

Confirmability refers to whether the findings can be confirmed by others (Lincoln & Guba, 1999). It is also known as neutrality which refers to the freedom from bias in the research procedures and results (Krefting, 1991). An audit trail was used to determine if the conclusions, interpretations and recommendations could be traced to the source. The audit trail consisted of raw data: viz. the recorded audiotapes and filed notes; data reduction and analysis: viz, writing up of field notes, summaries and condensed notes; data reconstruction and synthesis: viz, themes that were developed, findings, conclusions and the final report; process notes: methodological

and audit trail notes; instrument development information: viz, pilot study to refine the questionnaire (Babbie & Mouton, 2001). Actual quotes from the participants were also used in the written report of the study.

- **Reflexivity**

Horsburgh, (2003, 308) states that “reflexivity refers to the active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation”. The researcher kept a self-reflective journal to acknowledge prior assumptions and experience, throughout the research study. The researcher also remained aware of the purpose of this study during the course of the study. The researcher also enlisted the assistance of a colleague during the focus group discussions - to ensure that own presence, participation and personality did not prejudice the data collection process.

### **3.7 RESEARCH ETHICS**

Research ethics focuses primarily on the protection of the research participants but also includes aspects of scientific misconduct and plagiarism (Wassenaar, 2006). It is consequently important to obtain permission from the relevant authorities to conduct research.

#### **3.7.1 Permission**

Ethical clearance of the proposal was obtained from the Ethics Committee of the University of the Western Cape. The project was also registered (see appendix 1) with the University of the Western Cape (Project No. 11/8/12)

The proposal was presented to a review committee within the School of Nursing before it was recommended for submission to the Higher Degrees Committee of the university.

The proposal was subjected to scrutiny by the Higher Degrees Committee of the university before it was accepted.

Permission to conduct the study using student and educator participants was obtained from the Dean of Research (Appendix 2).

Permission to conduct the study using clinical staff from the four psychiatric hospitals was obtained from the Chief Executive Officers of the psychiatric hospitals in the Western Cape (Appendices 3, 4, 5, 6).

Permission to conduct the study using community mental health nurse participants was obtained from the Director for the Department of Health in the Western Cape (Appendix 7, 8).

A language editor edited this thesis (Appendix 9)

### **3.7.2 Informed consent**

Participant information sheets (Appendix 10) and consent letters (Appendix 11) were disseminated to all the participants - explaining the purpose, ethical considerations and guidelines for participation in the study. Individual written consent was requested from the participants. Participants were informed of the use of a moderator and the audiotape.

### **3.7.3 Voluntary participation**

Participants were informed that participation in the study was voluntary. They were informed of their right to withdraw from the study at any stage of the process, without any prejudice. This was especially stressed to the student participants as the researcher was a lecturer. They signed a voluntary consent form (Appendix 11) indicating their willingness to participate in the study.

### **3.7.4 Anonymity and confidentiality**

Confidentiality was ensured by not using the participants' names in the study. Student participants were asked to sign a focus group confidentiality agreement (Appendix 12). It is important to acknowledge to the participants that the researcher had no control over information that was discussed outside the group. Audacity software was used to disguise the participants' voices on the audiotapes, so that the resulting data could not be linked in any way to the identity of an individual. The interview tapes are kept in a locked safe to which the researcher had sole access for a period of five years, in the event of any queries from participants. The reporting of the data maintained the anonymity of the participants.

### **3.7.5 The principle of beneficence**

All participants have a right to be protected from discomfort and harm (Brink, 2007). The questions in the study may have evoked feelings of distress and therefore, the researcher monitored the participants for signs of distress. Some of the students participating in the study appeared distressed, as many personal issues emerged during the focus group interviews. The researcher then spent time with the participants after the interview to listen to their stories. The students were also encouraged to attend the student support services which were negotiated in advance. They, however, declined, citing that they felt better following the "off the record" discussion.

## **3.8 DISSEMINATION OF RESULTS**

The results of this study will be disseminated to the participants of this study through presentations and seminars. The research report will be available in the university library and the results will be reported as publications in accredited journals. The



researcher acknowledges all the assistance of others, as well as sources from which information was obtained as detailed in the report.

### **3.9 SUMMARY**

An in-depth description of the research design and methods which were utilized in this study was alluded to. A description of the theory generating process in the development of the proposed model was given. Research ethics and trustworthiness were also discussed. A summary of the steps of the research is illustrated in table 3.4 below:



TABLE 3.4: SUMMARY OF THE RESEARCH PROCESS

THEORY GENERATION LEVEL	RESEARCH METHODOLOGY		REASONING STRATEGY	RESULTS
<b>Step 1: CONCEPT IDENTIFICATION</b> Identification of concepts, classification of concepts, definition of concepts	<i>Population</i> Students, educators, clinical staff  <i>Sample</i> Purposive sampling  <i>Method of data collection</i> Focus group interviews, in-depth interviews,  Concept identification from validated narratives, observation and literature	Coding according to Tesch's method: Independent coder Themes and categories Literature control  Survey list (Dickoff et al, 1968) Dictionary and subject definitions of concepts	Inductive Analysis   Concept Synthesis	See 5.2.1.1- Identification of concepts  See Table 5.2 Concept classification  See 5.4 Definition of concepts
<b>Step 2: MODEL DEVELOPMENT</b> Development of relational statements		Concept development Statement development (Walker & Avant, 2005)	Synthesis	See 5.10 Relational statements
<b>Step 3: MODEL DESCRIPTION</b> Overview Purpose		Structure and process description according to Chinn & Kramer (2004) Evaluation of the model by using the strategies of Chinn & Kramer (2004)	Synthesis	See Figure 5.2 Model and 5.11 Process description of the model
<b>Step 4: GUIDELINES TO OPERATIONALISE THE MODEL</b> Guideline development		Guidelines to operationalize the model in practice, research and education Deductions and recommendations	Synthesis Deduction	See 5.12 Guidelines

## CHAPTER 4

### PRESENTATION OF THE RESULTS AND DISCUSSION

#### 4.1 INTRODUCTION

This chapter presents the results of the analysed data of all participants: that is focus group interviews with students; semi-structured interviews with educators from the participating university, the clinical staff from the four psychiatric hospitals in the Western Cape and a community mental health clinic. The results will be a discussion of the findings in conjunction with the literature control which serves to recontextualize the findings. These research findings represent step one using the theory generation framework to develop an emotional support model for students working in mental health care settings. Step one is the data collection process and concept identification.

The inductive approach was used for data analysis as described by Tesch (1990) in Creswell (2004). The participants' transcribed responses were read and reread to become conversant with the content. Numerous text units were developed during the coding process. These units were analysed in order to make sense of them and to form categories. As stated in Schurink, Fouche and De Vos (2011) - category formation involves observing for categories that are internally consistent but distinct from each other. The following step was to organise the categories and attach meaning to them, in order to derive a thematic description for each of the research questions for each participant group. Every category and theme is substantiated by quotations from the raw data. It is compared and contrasted with relevant current literature and research, to determine the experiences and emotional support needs of

students working in mental health care settings as perceived by the students, educators and clinical staff working in mental health care settings.

This chapter is organised into three sections. Sections one and two presents and discusses the vertical themes that emerged during the data analysis process derived from the categories of the three participant groups - namely student nurses, educators and clinical staff. The third section presents the horizontal themes which cut across the vertical themes of all the participant groups and presents an integrated discussion on the vertical themes and the literature.

Section One presents the analysis results of the focus group interview transcripts of fourth year nursing students in step one of the data collection process. Their experiences of working in mental health care and their emotional support needs are discussed.

Section Two presents the analysis results of the semi-structured individual interviews of educators and clinical staff in step one of the data collection process. Their observation of the students' experience of the mental health care settings and how they assisted students to cope with the experience ie the strategies educators and clinical staff employed to support students and their perceptions concerning the support needs of the students from the participating HEI and the clinical setting, are discussed.

Section Three presents the themes and discussions across all participant groups.

As discussed in chapter 1, the presentation of this dissertation did not include a literature chapter – nonetheless an integrative discussion of the findings and the literature is presented in this chapter. The researcher conducted a literature search to find a literature control. Literature on the experiences of student nurses working in mental health care settings was sparse; most of the literature was anecdotal. A subject librarian assisted the researcher in the search for the literature control. The

following computer-assisted data based bibliographies were searched: MEDLINE (Medical Literature Online), Academic search premier, Nexus and CINAHL (Computer Index to Nursing and Allied Health Literature), Ebscohost, SpringerLink, Science Direct, Scopus and the library. Combinations of keywords were used, namely: emotional support, emotions, student nurses, mental health care, social support, coping. Most of the keywords were linked to student nurses and mental health care. The literature obtained has been integrated into the results and discussions of all the participant groups.

A summary of the themes and categories for all participant groups is presented in tabular form, for example see Table 4.1. The theoretical framework, according to Lazarus & Folkman's transactional stress-appraisal-coping model (see chapter 2), was used as a basis for the study to capture a range of student experiences in the mental health care settings and also to structure the analysed data under the following headings:

- 1) Emotional responses which encompasses the following aspects:  
(i) organisational, (ii) sociological, and (iii) psychological aspects;
- 2) Coping (students): adaptive and maladaptive; coping strategies used (educators and clinical staff) and
- 3) Emotional support needs which depict the identified needs concerning the HEI and clinical settings separately.

Units of meaning are not illustrated in the tables but are used to aid the discussion of the findings. The raw data is used to substantiate the interpretation of the findings in the narrative discussion that follows each table.

## **4.2 SECTION ONE: RESULTS OF STUDENTS**

This section captures the students' experience of the mental health care setting in relation to the emotional challenges they experienced, how they coped or did not cope and the identified support needs.

### **4.2.1 Results of focus group interviews with students**

The focus group interview results being presented address two objectives, namely:

- To identify the emotional challenges experienced by students working in the mental health care settings
- To describe the emotional support needs as perceived by students.

The following research questions were asked to determine the aforementioned objectives:

- *Tell me about your experience of working in the mental health care settings?*
- *Tell me about your feelings in these specific incidents?*
- *How did you cope?*
- *What support do you think would you have needed to enable you to cope with the situation emotionally?*

The students' experiences were unique and original verbatim statements were used to illustrate the interpretation of the meanings students' attached to the mental health experience. However the results are presented as themes as they represent the meanings that the group of students attached to their experiences.

Students' experiences in the mental health care setting demonstrated a wide range of positive emotional responses; however, the emotional responses were predominantly negative as outlined in Table 4.1.

#### 4.2.2 Emotional responses of students

**Table 4.1: Themes and categories of students' emotional responses related to working in mental health care settings**

THEMES	CATEGORIES
<p><b>Organisational</b>  <b>1A:</b> Negative staff attitudes influenced by the transitory nature of students' placement increased the students feeling of being unprepared, undermined, prejudiced and alienated - however incongruence resulted when the students witnessed the staff rendering mediocre nursing care</p>	<p>Staff's lack of acceptance of the senior students, the impact of the transitory nature of students' placement and their unpreparedness to work in mental health care settings elicited feelings of alienation in the students.</p> <p>The emotional experience undermined the students' ability to assist patients.</p> <p>The attitude of staff, their prejudice regarding age and UWC students - impacted negatively on the students' emotional experience.</p> <p>The mediocrity of the nursing care led to students experiencing negative emotions regarding the clinical setting</p>
<p><b>2A:</b> Stigma by association, violence and the physical appearance of patients were related to students feeling fearful and traumatized.</p>	<p>Students' fears were possibly related to stigma by association, the reality of staff as patients, the patients themselves, the clinical environment and the stories that they heard.</p> <p>Acts of violence involving patients, staff and students caused students to feel fearful and traumatised.</p> <p>Students were traumatised as a result of the patients' behaviour and physical appearance</p>
<p><b>Sociological</b>  <b>3A:</b> Socio-cultural beliefs about mental health care users evoked feelings of confusion in some students and others experienced it positively - as they were able to assist their families with the knowledge gained.</p>	<p>Strong cultural influences regarding the belief in myths about and stigmatization of mental health users confused some students as they learnt about mental illness.</p> <p>Students' confidence to assist their families increased as a result of the knowledge gained through the emotional experience</p>
<p><b>Psychological</b>  <b>4A:</b> Negative affective states, altered cognition, physiological and behavioural signs and symptoms, and carer stress impacted adversely on the students' will</p>	<p>Students' self-reflection and questioning of the existence of mental illness, created inner turmoil.</p> <p>Students became judgmental and non-therapeutic when reports of the patients'</p>

<p>to seek support and their attitude towards mental illness. However, some students' experience was positive as they developed self-awareness which resulted in self-diagnosis and self-management</p>	<p>behaviour were negative.</p> <p>Alterations in sleep patterns; gastrointestinal, respiratory and cardiovascular effects relating to the students' experiences in the mental health care setting were reported</p> <p>Crying and irritability occurred as a result of the emotional experience</p> <p>The emotional attachment and the inability to detach from the experiences, despite the personal perception of professionalism, resulted in students feeling consistently burdened by the experience.</p> <p>Students' self- and other diagnoses based on real or perceived signs and symptoms of mental illness, created fear and shame which negatively affected their support seeking behaviour</p> <p>The experience and knowledge about mental illness resulted in self-awareness which led to self-management.</p> <p>Alterations in cognition and sleep occurred as a result of the emotional experience.</p> <p>Negative experiences resulted in students displaying a negative attitude towards mental health care.</p> <p>Positive attitudes of patients and staff resulted in a positive experience for students.</p> <p>The source of students experiencing the signs and symptoms of burnout were multi-factorial.</p>
<p><b>5A:</b> Age was perceived to influence students' emotional experience. Students identifying with patients' histories educed supressed feelings</p>	<p>Students perceived their youthful ages as bearing an influence on their emotional experience.</p> <p>Students identified with patient histories which educed their own supressed feelings.</p>

The results are presented per theme and category - focusing on the verbal and non-verbal responses, group interaction, field notes and researcher memos written during the data analysis process. The results are guided by Lazarus's transactional model



and the assumption relating to man being a body, mind and spirit as purported by Kotze (1998).

The themes elicited relating to the organisational, sociological and psychological emotional responses of nursing students working in mental health care settings are as follows:

### **1) Organisational emotional responses of students**

Organisational emotional responses refer to the organisations (HEI and mental health care environment) influence that evoked an emotional response from students. The following theme emerged after sense-making of the categories during the inductive analysis.

**Theme 1A: Staff attitudes were negatively influenced by the transitory nature of students' placement; which increased the students' feeling of being unprepared, undermined, prejudiced and alienated. However, incongruity resulted when the students witnessed the staff rendering mediocre nursing care.**

The organisational culture of the mental health care environment compounded the student nurses' emotional distress. Organisational culture here refers to everything that staff in the mental health care settings think, do or make. This includes the ideas, morals, languages, attitudes and feelings which are shared by the staff and which are consciously or unconsciously passed on to the students (Silove, 2004). The students' appraisal of the organisational culture was mostly negative. Students felt powerless because they were not permitted to influence direct patient care. They attributed this to the clinical staff's perception that their presence in the wards was transitory in nature. The following quotations illustrate this:

*“...you come as a student...for a few days...the permanent staff will say... we [have] been here. We know how to handle this patient...you can't... make any changes for few times because you won't be here so long to [with] these patients”* The transitory nature of their presence refers to the clinical placement programme as described in chapter 1.

Given the distress experienced by the self, it is not surprising that the students undermined their own ability to be of help to the patients. Whilst students felt the need to assist patients, a sense of helplessness and hopelessness prevailed making them perceive their role in caring for patients as insignificant.

*“It ... makes you depressed because you see all this [these] problems. You can't really help. You try to help but you [are] not important enough to help them”*

*“...it makes you feel... you can do something but what can you do?”*

The students' sense of dejection may be attributed to their clinical inexperience and lack of self-confidence in rendering effective nursing care, which in turn has decreased their self-esteem. This may have contributed to a sense of feeling devalued where students felt that they were *“not important enough”* to be of assistance to the patients. However, they attempted to assist the patients' although they did not believe they could make any difference in the patient's lives.

This was further compounded by the students being uncertain of what was expected of them in the mental health care settings. The uncertainty appeared to be based on their own opinions of what was expected of them rather than the actual expectations. They assumed that both the clinical staff and the patients would have certain expectations of them but because of their unfamiliarity with the mental health care environment, they did not know what these expectations were. This appeared to conjure up feelings of unpreparedness for working in the mental health care setting.

The feelings of unpreparedness were experienced despite being exposed to an orientation prior to being placed in the mental health care environment. These feelings are illustrated by the following quotations:

*“Even though you actually want to go to the workplace, inside you get scared. You don’t know what to expect...You don’t know what the staff is going be like...”*

*“I don’t think anything can really prepare you until you actually come to the setting...you can sit in a class but if you don’t see the actual patients in the hospital, you can’t really be prepared. The orientation...gives you a brief, but nothing can really prepare you”*

The students’ unpreparedness appeared to stem from the lack of exposure to the mental health patient population and the disease profile of patients. Although the participants had three years of general nursing clinical experience, the management of mentally ill patients requires a different set of clinical skills. These skills referred to in chapter one includes, among others, the use of the self as a therapeutic instrument. These skills need to be learnt and the students may at first not feel confident in the application thereof when caring for mentally ill patients. However, it appeared that the students felt undermined - they felt that the clinical staff did not acknowledge their seniority as regards general nursing knowledge or experience. They reported being dissuaded from implementing what they had been taught, as reported by this student:

*“Sometimes I’m told ‘no, don’t do this because you...bringing your own things. We do things here like this’ ”.*

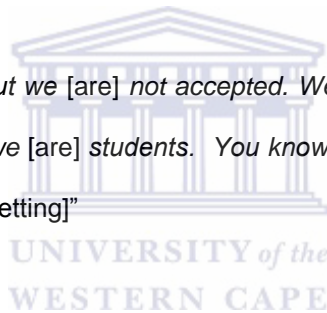
The case mentioned above may be an example of group closure, where groups (clinical staff) keep clear boundaries between themselves and others (students), which can result in the others (students) feeling alienated as they attempt to

penetrate a closed group without success. The feelings of alienation increased when students experienced the non-involvement of the clinical staff. Staff were perceived to be distant and *'minding their own business'*. The perception of indifference displayed by the clinical staff impacted negatively on the students' emotional experience, as illustrated by the following quotation:

*"...I always felt left out...people [clinical staff] mind their own business"*

Students reported feeling that they did not belong. This was because they were not permitted to utilise the staff clinical support services although they were working in the settings. The disparity between the students and clinical staff's access to support services, made the students feel *"not welcome"* and being *"outcasts"* - as reported by a student who said:

*"...there are services around here but we [are] not accepted. We [are] not welcome to use those services, just because we [are] students. You know when it's students, you like outcasts in the field [clinical setting]"*



The students were of the opinion that when the clinical staff did interact with them, they were prejudiced against them. Prejudice was as a result of the students' youth, as illustrated by the following quotation:

*"...because we [students] are young... they [clinical staff] stigmatise you. You're young, you... fresh out of school, you... know nothing about psychiatry or how to...handle the patients".*

There appeared to be a perception that the students were inexperienced because of their relative youth in terms of their chronological age. However, cognisance should have been taken of the fact that they were fourth year students with clinical exposure to nursing education and training; they had also followed the same nursing curriculum as their older counterparts. It can therefore be inferred that maturity was

linked to age rather than life experiences, implying that older students knew how to manage mentally ill patients.

In addition to the issue about age, students also indicated that the staff were prejudiced against them because they were studying at the University of the Western Cape. The prejudice manifested itself when they were blamed for negative incidents (scapegoating) and called derogatory names with particular reference to the University of the Western Cape (UWC) - as illustrated by the following quotations:

*“UWC nurses know nothing. They don’t know how to work. They only know the books ...”*

*“if anything happens “it’s UWC students, they don’t know their work, they are lazy”*

It would appear that the students were seen as having theoretical knowledge rather than clinical experience, hence perceived laziness being equated with inexperience. However, some students were called names and insulted as illustrated by the following statement:

*“They [clinical staff] call us licensed to kill”*

Whilst this statement was not interrogated, the researcher’s interpretation is based on cogitations of students during class reflection on their experiences in mental health clinical settings. During focus group discussions where this issue was raised, some students shifted uncomfortably in their seats as if embarrassed by the view that although they had passed the content of the psychiatric nursing module (*licenced*), they were perceived as posing a danger (*to kill*) to the patients. The other students nodded in acknowledgement. One student gave a nervous laugh and said *“Yes, that’s what they call us”*.

The above-mentioned may be stereotyping of students by clinical staff, which according to Opperrario and Fiske (2001) is attributed to interpersonal communication that transpires in the mental health care environment. These authors assert that stereotypes refer to the attitudes and judgements of clinical staff about the students, based on what they have learnt through communication with others rather than personal experience. Through stereotyping clinical staff presume to understand students' characteristics, which may negatively influence the students' emotional experience. This is how a division between the in-groups (clinical staff) and the out-groups (students) is maintained. It may be difficult for the clinical staff to correctly interpret information relating to the students' actual positive behaviour because of their negative bias toward the students. The result may be communication breakdown which may manifest in the students exhibiting negative emotions.

The students reported experiencing a myriad of emotions, horror, empathy and rage, when witnessing patients receiving standard nursing care - as illustrated by the following quotations:

*"It was horrible to experience what people is [are] there behind closed doors and how they [clinical staff] treat the people..."*

*" staff is [are] taking advantage of the mental health users...if you can put yourself in the [their] shoes... would you like this [these] services that ... your sister or...brother will be getting. ... it's ...boiling you inside when you watch such services"*

It would appear that they felt powerless to act against the mediocre nursing care as they reported 'watching' how patients were treated. The intense anger experienced by the student may be in response to the recognition of the mental health patients' vulnerability and a sense of powerlessness to act in the patients' defence or assume an advocacy role. However, given the earlier discussions relating to students being

perceived as theoretically loaded, and being undermined and devalued, and their contributions to patient care nullified as “*bringing your own things*” - it is thus no surprise that the students felt powerless. Their sense of self was eroded resulting in a lack of self-confidence and self-esteem, making them mere observers rather than contributors to the mental wellbeing of the patients. Students may have felt that they have no right to be heard, as they were the newcomers in an established entity with a strong organisational culture.

The interpretation of the experiences described by the students is fraught with irony. Whilst the students experienced the mental health care environment as unsupportive, largely based on the clinical staff's negative attitude towards them, they also perceived the clinical staff to be failing in the execution of their core function – viz. nursing care, as the patient care witnessed by them was perceived to be mediocre.

**Theme 2A: Stigma by association, violence and the physical appearance of patients were related to feelings of traumatised and fear in students.**

The feeling of fear was a major contributor to the manner in which the students experienced the mental health care environment. Fear resulted from manifold sources and generated different responses in the students.

Some students' fears were related to possible stigma by association and the fear of becoming mentally ill, as illustrated by the students who said:

*“...you see the people that worked in the mental places...admitted as patients...that is scary to think that one of these days you are also going to be a user [patient]”*

*“...for...me, it was fear from the very beginning. I was afraid. The fear for me... was to end up like them, the patient, the health care users”*

The reality of this possibility was exacerbated because students actually experienced

having to care for mental health staff that had become mentally ill. It appeared that the students felt that a diagnosis of mental illness was inevitable. This fear may be related to the students having similar trauma histories as the patients (see discussion on personal trauma histories), which made the students realise their own vulnerability/fragility to becoming mentally ill.

As mentioned earlier, students reported reading about patients' histories and hearing stories about patients' behaviour. Students described experiencing feelings of fear and traumatisation when hearing about mentally ill patients' violent behaviour and acts of violence involving patients, staff and students. The fear was based on stories they heard about dangerous patients which may have affirmed students' beliefs about danger and mental illness, as illustrated by the following quotations:

*"... I hear the stories, I started there on Monday... that...one nurse was raped... I got scared"*

*"I was very, very, very [emphasis] scared because I would hear some stories about the nurses being injured by the patient especially in psychiatric hospitals..."*

The violence was not only related to stories they heard, some students actually witnessed patient violence against the clinical staff, as illustrated by the following quotation:

*"I saw the patient injured [injure] a sister [professional nurse]. ... I was so scared...it could be me today so I'm not gonna [going] go to hospital"*

The consequence of witnessing the violence led to a fear for personal safety and resulted in the student staying absent from the placement. This student may have felt at risk of being injured or emotionally distressed. Remaining absent may have been perceived as protection from harm, which aided the student to cope with the stressful



situation. It appeared that the violence in the mental health care setting was perpetuated by the clinical staff who physically assaulted the patients, as was reported by the following students:

*"...you see the staffs [clinical staff] they hit the patients. I can't get rid of the feelings...can't go to school...I don't know what is happening to me"*

*"...I saw the abuse of two users [patients] where they placed me... that was very traumatic"*

The emotional distress experienced by the students may have been intensified because the patients were mentally ill and were admitted to receive care; instead they were subjected to physical abuse by the very people who were required to care for them. Ewashen and Lane (2007) assert that nursing students may experience secondary traumatic stress when witnessing patient distress, especially if they feel uncertain about the method of managing the patient distress. Students were however not spared from physical abuse by patients. Students reported incidents of violence perpetrated by patients against them, as illustrated by the following quotations:

*"... the patient smashed [hit] me but not on the face. Also twist my wrist"*

*"They spit on me...kick me. They tried to bite me..."*

The students who reported the violence were physically traumatised by the patients' actions, which may have reaffirmed the belief that psychiatric patients are violent by nature.

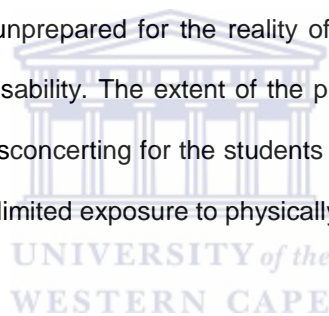
In addition to the violence, students were fearful and traumatised by patients' behaviour of a sexual nature towards them and the physical appearance of intellectually disabled patients; some students reported:

*“...the patients would...touch me...at first I never...said anything...I’d go home feeling very traumatised or...sad...”*

*”...the patients would...stand...at the glass windows and just look at me. It’s almost like they were undressing me with their eyes. I was very very[emphasis] scared even to go out to them. It took me a very, very long time to...interact with them because I was so scared”*

*“You do not know what you must expect. Maybe a patient is so deformed...you are actually shocked. You are expected to see this patient naked...wash...and...touch them. You are so traumatised”*

It appeared that the students were unprepared for the reality of caring for patients with mental illness and intellectual disability. The extent of the physical deformity of intellectually disabled patients was disconcerting for the students who reported being ‘shocked’. This may be as a result of limited exposure to physically disabled people.



## **2) Sociological emotional response of students**

Sociological emotional response in this study refers to the socio-cultural beliefs that evoke an emotional response in students. The following theme emerged after making sense of the categories during the data analysis process:

**Theme 3A: Socio-cultural beliefs about mental health care users evoked feelings of confusion for some students while others experienced it positively as they were able to assist their families with the knowledge gained.**

The participants had diverse cultural backgrounds which influenced their beliefs and understanding of mental illness. The traditional beliefs of bewitchment related to

people who displayed psychiatric symptoms were evidenced from students who reported:

*“having to learn about the psychiatric diseases and conditions... is a bit different.. I’m coming to [from] the Eastern Cape, rural area - if you see an old lady who is disorientated, who talks about people who died a long time ago, the people will say that person is a witch and that person gets killed”*

*“Going back looking on [at] the background where...I was born from [in] Kwazulu Natal...I know that these people are psychiatry people. They were mentally ill. Back that time I always believe[d] that this is witchcraft...If we take them to sangomas [traditional healers] and sangomas will perform everything...you believe that she has been cured”*

The aforementioned quotation refers to the isiZulu culture; however the following similar experience was reported in the isiXhosa culture where the student said:

*“as a black guy and also a Xhosa who grew up in rural areas where people...maybe three or four guys in that environment are psych [psychiatric] patients. We failed to understand that. You tend to find out that most of them... they are dirty...eating dirty things. We hardly understand that...they might be...mentally challenged or mentally ill. We thought that ... if we see someone like that...is just witchcraft. So for me it gave me a better understanding”*

The influence of students’ cultural background impacted on the need to form a therapeutic relationship with the patient. A student reports exercising caution - ‘get yourself....armed’ - which is interpreted as wearing spiritual armour such as having faith, when approaching a patient who displays psychiatric symptoms. The

preparation may have been deemed necessary to ward off evil influences such as Satanism, as illustrated by the following quotation:

*“..have this background I have been bewitched or suspecting that the one who is sick...is a witch ...when you come across the person...I get observant...I had this patient who was...praying to herself...for me to get closer to her, I told myself, I need to sit in a distance just to hear is she's praying? What is she praying? What is all this pray about? Because...there are...Satanists. You need to...get yourself...armed before you approach anything...I sat in a distance...listening...she prays a lot. Then I approached her”*

Cultural and ethnocentric beliefs appeared to influence students' understanding of mental health. It was evident that the student questioned his cultural background. The mental health experience evoked a sense of 'rootlessness' as the student felt that beliefs were based on myths rather than facts, as reported:

*“Well, emotionally, it made me feel I don't know where I'm coming from because of the way we do things. The way we judge people because it is not based on any... facts...it is just myths.”*

Conversely, the mental health experience was also deemed as having a positive effect on the student. Some students reported that learning about mental illness increased their knowledge and understanding of mental illness. Confidence in the ability to assist family increased as a result of working in the mental health care settings. The student reported:

*“... because I had a little bit of knowledge. I could help my family... telling them what to do and how to be supportive and that made a difference for me”*

### 3) Psychological emotional response of students

Two themes relating to the psychological emotional responses and physiological symptoms were generated inductively from the voluminous data, which was collected during the focus group discussion with the students. The identified themes captured the emotional experience by referring to: the emotional experience and the self-concept; the challenges experienced by the students in the mental health care setting and the impact of the workload as experienced by the students.

**Theme 4A: Negative affective states, physiological symptoms and altered cognition impacted adversely on the students' will to seek support and their attitude towards mental illness: however some students' experience was positive as they developed self-awareness which resulted in self-diagnosis and self-management**

Negative affective states include the emotional distress experienced by students when they worked in areas such as admission units in psychiatric hospitals and hospitals where patients with intellectual disability are admitted. Reflections bearing witness to the type of patients cared for in these specific areas were fraught with inner turmoil. In order to process the distress to make sense for the self, a student recounted questioning the involvement or non-involvement of a higher power to gain deeper understanding into the spiritual realm as is illustrated by the following quotation:

*"...there are some places... admission psych [psychiatric] units...IDS [intellectual disability]...that [are] so emotional. You [student] cannot be ok. Then [I] wonder, God what's happening? Why You doing this? God are you there?"*

While the student questioned God's purpose or role with human suffering, another student felt that all individuals had a predisposition to mental illness by virtue of being

a human being, as illustrated by the following quotation:

*"...all of us...have something...we just control it... the others they can't control it, that is why they're in the mental institution. You've got to question yourself sometimes"*

However, sense-making for this student meant that being admitted to a mental institution depended on an individual's ability to be in control of 'something'. This may be interpreted as human frailty, vulnerability or character traits that all human beings possess which make them susceptible to developing mental illness.

The above mentioned student was completing the final psychiatric placement after being exposed to both theory and clinical practice for almost one year. The learning expectation would be that students are conversant with the causes of mental illness which surpasses rudimentary knowledge.

In addition to observing patient behaviour, students are encouraged by the clinical staff to read patient files to assist in formulating nursing diagnosis and individual holistic nursing care plans. Extensive patient histories were recorded in the patient files. The students' distress intensified, they reported that they became judgmental and non-therapeutic in regard to patients whose histories made reference to negative behaviours such as criminal offences, for example robbery.

*"The more time I spend with the patients reading their folders...I had this thing of being judgmental"*

The student highlighted the internal moral conflict experienced when caring, which was ingrained in her professional view, was incongruent with her personal trauma history. It is apparent that the student's struggle to detach emotionally, especially when patient's had a forensic history as reported:

*“...you get to the work place [mental health care setting] and heard this person had... robbed someone. And it's happens to me... I ... look at this person with, you could have done it to me. Maybe you're the one that robbed me... you retreat from that person... you don't want to associate with that person...it's wrong because we're there to help but you can't...give your best”*

The student tearfully described how she was robbed by a person wearing a balaclava, which meant that she did not see the perpetrator's face. Her anxiety at not knowing who robbed her meant that even patients who had a history of robbery may have been the perpetrator.

Conversely, other students reported their inability to detach from the mental health experience resulted in them becoming emotionally attached to the patients. This resulted in students feeling consistently burdened by the experience, as illustrated by the following quotations:

*“It's difficult to cope...doesn't matter what it is, you [students] do take something home with you”*

*“they [lecturers and clinical staff] don't teach us the skill of how ... to leave what happened at work at work”*

Students displayed self-awareness at being *“too emotionally involved or attached to the patients”* but this awareness did not appear to alleviate the distress. This may be because they perceived themselves as lacking in skills to detach from the experiences, as these skills were not taught in class.

Pursuing a career in mental health nursing also appeared to be linked to students' ability or inability to detach from the mental health experience, as students reported that clinical staff judged them based on these factors. A student alluded to how she

was discouraged from pursuing a career in mental health by a professional nurse who admonished her, it was expected that she should have known how to distance herself because *“it’s just a patient”*.

*“...Sister [mental health nurse]...said, I don’t think you’re strong for [to work in] psychiatry because you take this story... you personalised it...you should be able to draw a line. It’s just a patient”*

The mental health nurses at the clinical placements sites are expected to facilitate the process of skills teaching, which students also learn by emulating professional behaviour. It is however not surprising that the student was distressed, as the attitude and behaviour of the mental health nurse was perceived to be unsupportive.

Negative experiences give rise to students displaying a negative attitude towards mental health. The negative attitude appeared to be the culmination of the staff’s attitude towards students and the patient population in mental health care settings. Students described mental health nursing as:

*“...psych [psychiatric nursing] is depressing...”*

*“... is an experience that I don’t want to go through again”*

*“...I cannot take it. I cannot work in psych [psychiatric nursing]”*

The emotional distress was apparent in students’ articulation of their experience, *“...I cannot take it [psychiatric nursing]”*.

Cleary & Happell (2005) assert that it is imperative that the students’ experience of the clinical placement is positive if they are to choose a career in mental health.

The unsupportive mental health care environment spilled over into how caring as a primary function of nursing was construed by the students. Students reported surface

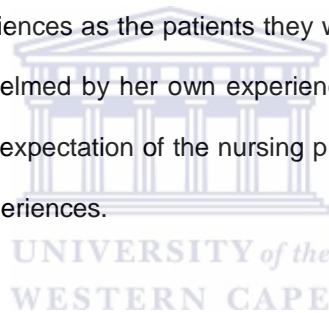


acting (Grandey, 2000) by 'faking' the emotion of being in control of themselves and the situation, when in reality the student was traumatised by what she had heard:

*"I remember sitting with patients telling me their story...you think, I've been through that...but you must keep a straight face and not say... I understand...you must be professional... you can't be a human being with emotions in front of your patient"*

Research (Grandey, 2003; Brotheridge & Grandey, 2002) suggests that 'faking' raw emotion may lead to negative experiences and outcomes. Students' distress increased when being a professional appeared to negate the expression of emotion.

The perception that professionalism required a lack of emotion appeared worse when students had similar emotional experiences as the patients they were caring for. The student may thus have been overwhelmed by her own experience, reappraised the situation and rationalised it to be the expectation of the nursing profession on how to care for people who share similar experiences.



The experience of being overwhelmed resulted in some students reporting sleep disturbances such as nightmares and cognitive difficulties, namely the inability to concentrate, as illustrated by the following quotations:

*"...I would have nightmares about those patients"*

*"...those memories are coming ... and I'm getting nightmares"*

*"...I try to listen and somehow I'm just like a block"*

Metaphorically speaking, reference to being '*just like a block*' - which in this case is interpreted as a piece of wood - describes feelings of disinterest and indifference, such as being physically present but emotionally detached which affects concentration during a conversation.

However, some students were unable to detach themselves from the experience and reported experiencing physiological signs and symptoms of distress. Vegetative symptoms such as hypersomnia, insomnia and lethargy which could be linked to depression were reported by students:

*"I always want to fall asleep because I am always tired"*

*"You can't sleep. You always thinking about this and that..."*

Other physiological symptoms experienced by students included loss of appetite, chest pain and behavioural symptoms such as crying when listening to patients' stories. Students reported:

*"I don't eat. I don't feel hungry"*

*"She was ....in tears when she told her story...I would end up crying as well"*

The student described being overwhelmed by the patient's distress and was thus unable to contain her emotions, which manifested as crying. A constricting chest pain which resulted from the intense anxiety experienced by a student, in response to the mental health experience is evidenced by the following quotation:

*"... you feel some pain from here...the chest. Like you can't breathe"*

This student was booked-off as being ill due to 'stress' at the time of the focus group discussions. She volunteered and participated in the focus group discussion despite her ill-health. The rationale for her participation was that awareness had to be raised about the emotional experiences of students in mental health care settings. This may be interpreted as the student's perception that the focus group discussion was a platform to raise her otherwise 'silent' voice. It may also have been cathartic (self-healing), in view of the student's physiological symptoms at the time of the focus group discussion.

In addition to the physiological signs and symptoms experienced by students, some students identified themselves to have specific conditions such as burnout, which students said they had learned about. The sources of some psychological signs and symptoms were multifactorial, as illustrated by the following quotations:

*"It has been as if everything has come at once...I could identify with the lecturer on burnout...because it was like me. It was where I was at that point"*

*"I am... emotionally drained...I am...exhausted. Burnout"*

Some students also reported feeling burdened by the mental health experience, which they referred to as:

*"... you carry a load of what you are taking from the patients"*

*"...people have experience a lot of things... when you hear all that...it gives a load to your shoulders"*

*"Can't explain it to you .... It's just the feeling...It's heavier. It pressurises you"*

*"... the environment... seems relaxing... they [the staff] say... you doing nothing.. When you get home, you're ....emotionally drained and tired...you realise... I haven't sit (sat) in the sun the whole day, I've worked...you must watch this person...that person... it isn't a relaxed area. It's an emotionally draining area"*

The experience was described as being inexplicable as it was a feeling of emotional overload and being emotionally draining. The similes used by students describe the intensity of their emotional pain which defies explanation and can be equated with a lack of emotion.

Sense-making of the emotionally draining experience for the student meant that psychiatric nursing involved '*mind games*', as illustrated by the following quotation from a student:

*“psych [psychiatric nursing]...drains you...mentally, because it is all mind games...”.*

Whilst some students appraised the mental health care environment as distressing, others diagnosed mental illness in themselves. They based their observations on real or imagined signs and symptoms of mental illness, with their rudimentary knowledge they made self- and other diagnoses of mental illness - as reported by the following students:

*“... it is very emotional because I see things in psych (psychiatry) I thought,... maybe I have that...I ask my friends, do you think I have that? It make [makes] you terrified”*

*“I could almost diagnose every psychiatric condition we did partly in myself”*

*“I am suffering from depression... you don't realise it until you...know what to look ... for”*

Self-diagnosis resulting from raising awareness is not uncommon in general health as well. However, the impact of being diagnosed as having a mental illness is worsened by the stigma associated with mental illness. This was especially true for these students as they reported experiencing feelings of fear and shame, which resulted in them not seeking assistance to deal with the emotional experience - as illustrated by the following quotation:

*“...I was also too ashamed to go there [student support centre] and say I hear voices or what is happening to me”*

However, although students identified mental illness in themselves, they also felt that having the knowledge and experience resulted in self-awareness which led to self-management. These students highlighted the importance of being aware of the self:

*“You must know who you are”*

*“...I ...have a personality disorder...I could manage it...because the first thing is to know oneself”*

Despite the experiences being challenging, positive staff and patient attitudes helped some students to cope with the emotional experience. In this respect the students' appraisal of the mental health care environment indicated that patients provided humour which assisted with coping, as conveyed by the following students:

*“I was very entertained by the patients and all ... the staff treated me well”*

*“... there's joy to psychiatric settings...the patients...I...spend...time with. I was forever laughing. He [the patient] tells me a lot of stories. What he does at school. Most of the time I enjoy myself and all the stories that I heard, all gone because of that joy”*

The student's positive mental health experience appeared to be linked to a patient, who despite his mental illness had the ability to narrate stories which made the student laugh. This patient's contribution to the student's experience is considered to be significant as it dispelled negative stories that were heard. The researcher's interpretation hereof is that the student may have consciously decided to associate himself with positivity (in this case the patient) in adverse conditions, to dispel any negative emotions. On the other hand, being knowledgeable about mental health nursing for another student might mean being able to cope with emotions:

*“There's a positive side [to psychiatric nursing] also because it helps you to cope with your emotions...”*

The student appeared to have utilised the knowledge, attitude and skills gained in mental health theory and practice, to enable her to deal with the mental health experience.

**Theme 5A: Age was perceived to influence students' emotional experience.**

**Student identification with patients' histories evoked suppressed feelings**

The challenges experienced by the students within the mental health care environment involved their attitude about their youthful age and the effects thereof, and of students identifying with patient histories. A student described how her age contributed to her feelings of intimidation in the mental health care setting, she had to "grow up quickly" in order to deal with the emotional experience:

*"...the whole psychiatric thing felt ... intimidating because I'm...young... it felt that I had to grow up very quickly... to deal with everything"*

The student may have been raised in a sheltered home environment, which is not unusual in the White South African population group. In contrast, her Black counterparts may have been exposed to various life stressors by virtue of their upbringing. Patients in mental health care settings are racially diverse with the majority being Black, consistent with the population demography of South Africa. In addition to being young, the student may thus have had limited life experience. The mental health experience therefore presented a challenge for the student, who had to deal with patients who experienced various life stressors for which she had no frame of reference, hence the feeling of intimidation. Lazarus and Folkman (1984) refer to situations where individuals have no prior experience as novel. However, most situations are not completely novel; the student may have heard or seen mentally ill patients during the prior three years of nurse education and training.

While some students had limited life experience, other students reported of identifying with patient histories. They appeared to recognise their own vulnerability

regarding mental illness, which created emotional turmoil as illustrated by the following quotations:

*“Some patients that are coming there, some other situation that...you [student] do have experience. Some they [patients] come with the problems that maybe you'll experience now or what's happening in the family. So it's very emotional”*

*“you thinking... this person is going through the same things that I am going through and this person is in a mental institute [institution]”*

It appeared that although students had similar histories as some of the patients, they had been able to suppress their emotions prior to working in the mental health care setting. However, once they were aware of the patients' histories their own suppressed feelings were educed. Sense-making for the students meant questioning their existence, which was perceived as being untrue to the self. This particular student felt that his/her life was pretentious:

*“Working with these mental disabled... and depressed patients brought out a whole lot of feelings that I've put aside for years... I saw myself living a lie and ... pretending that everything is okay...”*

#### **4.2.3 Coping experience - students**

In order to attain objective 2 and research question 2, participants were asked to describe how they coped with their experiences in the mental health care settings. Coping is the efforts that are required to manage external and internal demands that are appraised as taxing or exceeding the students' resources (Lazarus & Folkman, 1984). Various categories were generated from the data which produced two themes related to adaptive and maladaptive coping strategies. The range of adaptive and maladaptive coping strategies is depicted in table 4.2. A narrative discussion,

substantiated with quotes from the raw data, explicates the categories and themes which were inductively analysed.

**Table 4.2: Themes and categories of student coping in mental health care settings**

THEMES	CATEGORIES
<p><b>Adaptive</b></p> <p><b>6A:</b> Utilization of social support, intrinsic resources, self-care activities and knowledge to cope when the environment was appraised by the students as being unsupportive</p>	<p>Access to family, peer and staff support resulted in students being able to cope with the emotional experience</p>
	<p>Students dealt with their own issues in the absence of support</p>
	<p>Accessing intrinsic resources aided student coping when the environment was appraised as being unsupportive</p>
	<p>Inner strength gained through prayer instilled hope, perseverance and motivation in an environment which students perceived to be unchanging</p>
	<p>Students consciously diverted attention from unpleasant thoughts to deal with the emotional experience</p>
	<p>Students engaged in self-care activities to cope with the emotional experience</p>
	<p>Knowing how to manage patients increased students' confidence in their ability to deal with aggressive patients.</p>
<p><b>Maladaptive</b></p> <p><b>7A:</b> The utilization of defensive coping and behavioural strategies which were acknowledged to have short-lived effects.</p>	<p>Students ignored staff, blocked and disengaged from unpleasant experiences to cope with the mental health care environment</p>



	Students engaged in shopping, substance abuse and clock-watching to cope with the negative experiences in the mental health care setting
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Adaptive coping strategies focused on strategies which were deemed to be positive and thus illustrating student coping with the mental health experience.

**Theme 6A: Utilization of social support, intrinsic resources, self-care activities and knowledge to cope when the environment was appraised by the students as being unsupportive**

Students mostly accessed family, peer and staff support to cope with the emotional experience. The knowledge that the family provided a nurturing environment made the experience bearable for students, as illustrated by the following quotations:

*“...it’s looking forward to seeing my family on weekend...knowing I’m seeing them it’s a highlight for me...when I come back from (the) weekend, I feel more refreshed and know I can tackle this again”*

*“... I have a very supportive family”*

Peers also played a significant role in supporting students, which enabled them to cope with the experience as illustrated by the following quotation:

*“I know that even if my parents can be as far as Eastern Cape...if I’m having...problems, I’ve got my colleagues [peers] next to me. They will assist me...that’s what is keeping me going especially this year”*

The student mentions the fact that although his family were not in close proximity (they lived in another province in South Africa), his peers fulfilled the supportive role.

This was especially significant in the fourth year of the nursing programme, students

may have spent the previous three years adapting to university life, building relationships with others etcetera. Their friends may serve many roles and consequently they become reliant on each other for providing the necessary support. An interpretation is made that the students coped with the stressful mental health experience by venting their feelings to peers with whom they are familiar. What was significant is that these peers were working in similar settings and who may or may not have experienced similar situations.

These findings concur with a 3-year longitudinal study conducted by Lo (2002) on methods of reducing tension in nursing students. The students in the study indicated 'peer support' assisted them with reducing personal stress. Other students found talking to people aided coping, which made them feel less burdened:

*"...if you can talk to someone. It lifts that burden"*

*"...the best way to cope...is....to speak about it. Express my feelings"*

Talking about stressful events may be cathartic, therefore some students felt that communicating their distress to others made them feel better, which aids coping.

Communication from educators and clinical staff which illustrated their interest in the wellbeing of the students was also perceived to assist student coping, as reported by the following students:

*"...it helps when there's interest and the lecturer asks. How did you work? Did anything happen during the week...? It helps a lot"*

*"They (clinical staff) ask me how I am... That means a lot to me"*

Students appeared to value educator and clinical staff interest in them as persons. This interest may have been perceived by students as caring and therefore led them to believe that they were not alone in their experience.

Conversely, some students appeared to have learnt to deal with their emotions and thus appeared to know how to cope with the mental health experience. This self-healing occurred in the absence of other supportive resources and is illustrated by the following quotations:

*"Mostly you end up healing yourself"*

*"...if...I'm emotionally disturbed, I'll have to deal with that myself..."*

One student consciously supported herself through the use of intrapersonal communication by engaging in internal dialogues; this can be interpreted as having positive internal dialogue to reassure the self in the midst of adversity. Self-healing consisted of engaging in self-talk:

*"I do self-talk"*

Another student had learnt the value of looking within oneself to gain an understanding of one's emotions. This appears to have occurred at the beginning of the placement, when students were faced with the unfamiliar mental health care environment and they sought to make sense of the experience, as illustrated by the following quotation:

*"in the beginning...you start doing introspection into yourself"*

Some students reduced the threat (the negative attitude of the staff) by reframing the meaning of the situation. Reappraisal is illustrated by the following student who said:

*"...I tell myself...I'm not there for the staff. I'm there for the patients and the patients enjoy my presence"*

The student thus coped with the experience by focusing on the positive contribution her presence made for the patients. The student's interpretation of the meaning her

presence had for the patients may have been self-fulfilling, as she chose to justify her worth.

Other students engaged in prayer, seeking strength from a higher power, to deal with the mental health care environment which was perceived to be unchanging:

*"It's almost like (the) serenity prayer...Keep ...asking God every day...please grant me to accept the things that I cannot change. So that's the same...line that I say to myself every morning when I get up"*

*"...the fact...is true, prayer does help...in every situation..."*

The belief that they were not alone in the overwhelming situation, gave strength and hope to sustain the student and enabled coping.

Certain students reported possessing the ability to persevere despite the lack of perceived support. Lazarus and Folkman (1984) make reference to goal relevance during appraisal which affects coping. These students had set goals and despite the experience were motivated to complete their studies:

*"...not getting enough support from the university... what worked was knowing what I wanted and hanging in there..."*

*"...I said to myself... I will do it. I'm going to finish ..."*

These students' statements may be construed as the ability to persevere in an unsupportive emotional environment. However, Curtis (2007) alludes to the experience in mental health care settings as being so overwhelming, that some students aim is to survive the experience and complete the mental health module which may be perceived as being motivated to complete the nursing programme.

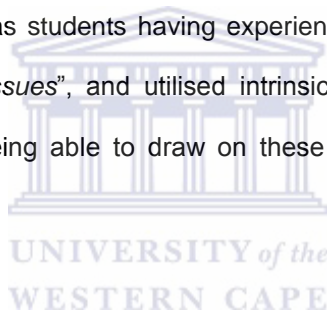
Motivation is the process whereby students display goal-directed behaviour in the actions that they take to complete the four-year nursing degree and achieve

something. They also display an ability to maintain that action which in this case may be persevering (using adaptive coping strategies) despite challenges experienced in the mental health care settings (Harper & van Vuuren, 2012).

One student referred to coping as having experienced stressors in life and performance developed skills which were utilised to deal with the negative emotions:

*“... by the time we reach...psychiatry... it’s [a] life time process of dealing with issues now...at least we would have learned the inside strength of how do we deal with our emotions”*

Student coping may be interpreted as students having experienced prior adversity, *“life time process of dealing with issues”*, and utilised intrinsic resources, *“inside strength”*, which aided coping by being able to draw on these resources to cope within the mental health care setting.



Certain students coped with the mental health experience by engaging in behavioural coping strategies. A range of self-care activities such as life skills training, recreational activities, leisure time and crying assisted students to cope with the experience. These activities served to make students channel energy elsewhere:

*“....it’s been 10 years I’ve been doing martial arts. We have stress relief, anger management classes. That was my way of escaping the bad situations. Stressful moments”*

*“....I ...play golf”*

*“...I take an hour a day for myself. I call it ‘me’ time”*

A different student reported on the importance of having a structure to aid coping:

*“you must always have structure. That’s the only way you cope”*

Structure is interpreted as being able to control certain aspects of one’s personal environment. Although the mental health care environment was perceived as being uncontrolled, sense-making for the student was through being able to control some aspects she was able to cope.

A student reported that the clinical experience in the mental health care setting and the knowledge she had gained during class, enabled her to manage aggressive patients. The confidence in her abilities increased resulting in allaying her fears, which in turn enabled coping:

*“Being there, I really see that every patient is not going to hit you. There is one that eye you the whole day that wants to...you’re taught in class how to deal with that...that is how I dealt with all those fears”*

While another student consciously diverted attention by means of cognitive restructuring, to deal with unpleasant thoughts:

*“...I ...start singing or...do something else, read or ...if the thought comes... into my head... I just think of something else”.*

Cognitive restructuring is the process of modifying thoughts that maintain the problem into thinking about something more positive (van Vuuren, 2012). Singing or reading may be activities which the student found to be comforting in dealing with distressing thoughts.

**Theme 7A: Utilization of defensive coping and behavioural strategies by students’ which were acknowledged to have short-lived effects.**

The need to regain some order and control in their lives caused these students to utilise various maladaptive coping strategies, which were mostly emotion-focused.

Certain students used defensive coping strategies to assist in coping with the mental health experience and the negative emotions which were evoked. A student reported ignoring staff as a way of coping in the setting:

*"...I was just wearing a rain coat; just ignore them and the bad treatment I get"*

Metaphorically speaking, "*wearing a raincoat*" describes the conscious decision by the student to ignore or disregard the negative attitude of staff so that it had no effect on the student's emotion. The student may feel that the attitude or behaviour of staff has no relevance to his/her goal attainment and thus there is no emotional response, therefore the student coped. This may also have been to protect the student against the negative attitude.

A number of students coped by distancing themselves emotionally and physically from the negative emotional experience:

*"...I started blocking - now it's not that easy... I'm faced with it all the time...right now it's in my face"*

*"...I withdraw from everything...I stay at home. I sleep"*

The student described the difficulties she experienced when the usual coping mechanisms of blocking the emotions was no longer effective. This was as a result of patients presenting with similar trauma, which served as a constant reminder of her trauma. Coping for another student, meant detaching herself from the experience by staying absent from the clinical setting. Using sleep helped her to temporarily forget about the experience, which aided coping.

Another student reported diversion was engaging in behavioural strategies to cope with the experience. Some students reported going shopping for clothes, '*retail*

*therapy,*' in an attempt to cope with the experience. However, they admitted that relief was only temporary as the negative thoughts are retained regardless of diversion tactics. A different student reported watching helplessly whilst his peer was abusing substances to cope with the experience. The student acknowledged that abusing substances was maladaptive.

*"My coping is buying a lot of stuff. When I feel sad, I buy bags, clothes, pants, new dresses... this semester only six months it cost R8 000 of just buying and buying"*

*"...shopping spree, retail therapy, but it doesn't help because it stays in your mind. It help (helps) for that moment when you go out"*

*"...you see your friend...drinking [alcohol] this much... this is not right"*

A student reported clock-watching while waiting for the day to end. Coping for this student meant the knowledge that the distress was temporary and that time brought relief at the end of the shift:

*"Most of the time I look at the clock and I can't wait for the day to get [be] over..."*

Given the short period (three to four week) of placement, it would not be surprising if very little learning/interaction with patients take place if students are distressed to an extent that they are merely surviving the experience.

Creating physical distance between the self and the patients in order to feel safe helped students to cope with the mental health experience:

*"I didn't want anyone to come near 5 foot... I just stayed at the nursing station the whole day...them (patients) there and me here..."*

The student described how she coped by protecting herself from the patients. This may be related to stories heard; media portrayal of mentally ill patients and not knowing what to expect caused fear in the students.



#### 4.2.4 Student emotional support needs

In order to ascertain students' emotional support needs whilst working in mental health care settings, the students were asked to identify the support they felt that they needed which would enable them to cope with the mental health experience. In table 4.3 the themes and categories identified from the data analysis illustrates the emotional support needs of students. Students identified specific needs related to the HEI and the clinical setting. Cognisance is taken of the interrelatedness of the support needs but in order to develop the model specificity is required, as the two institutions are distinct (see clarification of terms for HEI and clinical setting).

**Table 4.3: Themes and categories of students emotional support needs**

THEMES	CATEGORIES
<p><b>HEI</b></p> <p><b>8A:</b> Although students were aware of existing support services in the HEI, they proposed a multidisciplinary team approach, including academic and practice staff that possessed appropriate knowledge, skills and attitude, who served as role models to support students in the mental health care environment. Accessible counselling programmes across the four-year nursing programme is required to assist students to cope</p>	<p>The students identified an accessible, independent nurse or psychologist who was experienced, knowledgeable and skilled and possessed appropriate attitude to support them to cope with the emotional experience</p>
	<p>A support person who knew more than one language, of similar age who possessed attitude was identified by students</p>
	<p>Students identified an available lecturer with interpersonal skills to conduct support meetings to support them to cope with the emotional experience</p>
	<p>Students identified clinical supervisors, as they were available but should also possess sound interpersonal skills, to support them in the mental health care environment</p>
	<p>Students identified lecturer interest in their wellbeing, the value of role models as well as skills teaching to raise</p>

	awareness of important emotional support needs
	Students felt that weekly on-going supportive counselling namely debriefing, across the four-year programme would assist them to cope with the emotional experience
<p><b>CLINICAL SETTING</b></p> <p><b>9A:</b> Effective collaboration between HEI and clinical service to ensure that there were clear policies and procedures in place to support students. Mentoring programmes and counselling services with involved staff to support students in the mental health care setting.</p>	Liaison between the HEI and setting was deemed important in establishing an effective relationship that would support students in the mental health care setting
	Students identified having clear policies and procedures in place for orientation and self-care of students in the facilities
	Students identified mentors who had mentorship programmes, which included initial student orientation to support students in the setting
	Involved clinical staff who educated students, were identified to support students
	Accessible assessment and counselling service for students, to support them with the emotional experience

#### 4.2.4.1 Student emotional support needs relating to the HEI

Themes were formulated from the categories to capture the support needs related to the HEI, were identified by students.

**Theme 8A: A multidisciplinary team approach by staff and students from both academic and practice environments that possessed appropriate knowledge, skills and attitude who served as role models to support students in the mental**

**health care environment. Accessible counselling programmes across the four-year nursing programme to assist students to cope with the emotional experience**

The students identified individuals with specific skills, namely a nurse or a psychologist who was not a lecturer or a member of the clinical staff, as a support person. This was important, as an independent person would be employed to service the emotional needs of students and not have any other obligations such as teaching or clinical care. However some students felt that the educators would also be able to fulfil the support role. The person should be:

*“... an independent person...”*

*“... a nurse...”*

*“... a psychologist that has...experience in nursing...”*

*“... the lecturers. We are always in contact with them”*

*“... you [students] take a supervisor as your moral support; as your comforter...”*

*“... know... how to intervene”*

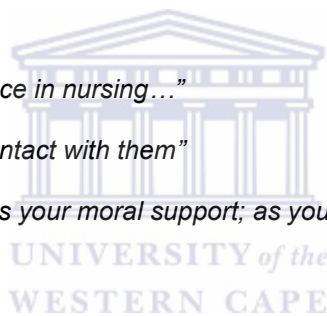
*“... a skilled person who knows how to handle and to give them... guidance”*

The psychologist identified as the support person had to have experience in nursing. Students may have felt that having experience in nursing would mean that the psychologist would have an understanding of their needs and also be empathetic to their experiences.

The students also identified some social and cultural factors which they felt would be supportive whilst working in the mental health care setting. This included support related to communication and is illustrated by the following quotations:

*“...is available to talk...”*

*“...be there all the time”*



*“...an open door policy...”*

*“our age...understanding...approachable...”*

*“... someone we can relate to”*

*“...someone who can understand not just one language”*

*“I feel the lecturer must ...have empathy”*

Availability and accessibility of the support person was highlighted by students, as they spend two days per week at the university and the other three days at the mental health care settings. They felt that the person should be situated at the School of Nursing. Given that the mental health nursing programme does not make allowances for time off during the week, the students may feel that the university support services are inaccessible and unavailable to them, as they are unable to access the support offered. This may also mean that the existing student support services do not meet nursing students' needs in terms of accessibility. Students have to make appointments which may mean that their emotional support needs are not addressed immediately. They may not be able to access the services on appointment dates, as the SANC clinical hour requirement for completion of training has very little room for absenteeism. This is especially true for fourth year nursing students who may have a shortfall of clinical hours from the other study years which they have to complete. A number of nursing students may not be aware of the university support services, given that the nursing programme differs from the general university population programmes which do not have a clinical component.

Other factors relevant to the identified support person include being the same age as the students, having the appropriate interpersonal skills and being bi- or multilingual. Students may feel more comfortable talking to someone who is within their age range, as they may feel that the person is able to identify with their experiences. As

students are diverse, they also speak different languages although the medium of instruction at the university is English. When one is traumatised, it may be comforting to be able to express one's emotions in one's home language. Some languages do not have words to describe certain conditions, for example 'depression'. There is no Xhosa word to describe depression and thus students may struggle to articulate their feelings thus supportive interventions may be perceived to be futile. The assumption may be that if the support person understands one's language, they may also be able to understand the context and hence the interpretation of the students' negative emotional experiences may be correct.

Some students, however, felt that the lecturer should be the person to render the support, as they are available and will understand what the students are experiencing in the mental health care settings. They felt that lecturers would need to be empathetic. Lecturers were also identified to conduct support groups for students: *"...a lecturer...to run those meetings [support groups]...the lecturer knows the person..."*

These groups may be important to students as they offer an opportunity for students to articulate their distress, share experiences and gain support from their peers. These will aid the student to understanding that he is not alone in his distress.

Some students identified the clinical supervisors as the support persons, as they were perceived to be offering support already but felt that they needed to be available at the mental health care setting.

Clinical supervisors supervise students at various mental health care settings, such as hospitals and clinics in the Western Cape. However, each clinical supervisor has

to service a student complement of about 30-40 students at the various hospitals and clinics in the Western Cape. This means that the student sees the supervisor once a week for a period of one hour. Thus, given the need for availability of supervisors for support to students, it may be interpreted that the students' need for emotional support by the clinical supervisor would not be met.

Students also alluded to the various roles and characteristics, values and skills that clinical supervisors, who are appointed to support them in the clinical setting, should possess:

*"...they can supervise...teach...and guide you..."*

*"...on a...mentorship...supportive and personal basis..."*

*"...supervisors... not only... there...for... evaluations, but...there on an emotional level to support you...as well as the lecturer..."*

*"...when they [the management at the School of Nursing] are appointed [appointing a] supervisor...people who have patience...not easily offended. They have to be firm but... cannot be judgemental and be offended"*

*"...supervisor should have a very, very good attitude on how to deal with students..."*

Students felt that clinical supervisors should also exercise supportive roles rather than only focusing on clinical evaluations, which is a learning objective. Given that students are exposed to mentally ill and intellectually disabled patients with a range of diagnoses, it is not surprising that students report that they may need emotional support as well. It would appear that students perceive the current role of clinical supervisors as ensuring that learning objectives are attained.

It is evident that students perceived clinical supervisors to be in possession of sound interpersonal skills. These skills were deemed important in supporting students in mental health care settings.

Other students felt that peers also had a role to play in emotionally supporting students. They identified the characteristics and functions for the group of peers they identified as 'peer mentors':

*"...peer mentors in fourth year...good strong leaders... You...know...I can...talk to the person. It will be kept private and confidential"*

*"...if...(in) every hospital...here (there) is...a student mentor..."*

*"...needs to be a person who's emotionally strong..."*

*"peer mentors...go for a training in counselling"*

*"...where to refer...to"*

Students felt that there were peers who were leaders and could thus serve as mentors to support students with the emotional experience. Peer mentors also had to be skilled in order to function effectively. It is evident that peer mentors were identified by students as they are seen to be more available. Given the descriptions of individuals identified by students in the earlier discussion, the peer mentor would meet the criteria identified by the students as a support person who would assist them to cope with the mental health experience.

Students identified supportive strategies that students felt were important for the self-concept. These included interest in their wellbeing and learning how to access internal resources. Lecturer interest in student wellbeing was perceived to be supportive for the self (personal support). This may be that students felt that the lecturer cared for them because of the enquiry about their wellbeing. Students also felt that they needed to be taught skills that would give them insight into their inner selves. They would then learn how to access the intrinsic resources to cope with their emotions:

*"...if the lecturer ask me in the morning how are you? that's enough for me"*

*“...be told coping skills. How to...cope...(with) what...happens during the four years that we studying”*

*“... we need to be taught all those inside world. How do we become in touch with ourselves? Let me sit down with my soul. What do I feel?”*

Students reported that they needed to know what the expectations of the four-year nursing programme were, as it appeared to be unknown. This is important as students need to have some degree of control over their education as it may have a negative impact on how they plan or organise their daily lives (Stranks, 2005). They also needed to know how to deal with issues that may occur. Nursing is not the first career choice of some students and due to lack of interest they may not be conversant with the expectations of the nursing programme.

The importance of having role models which students could emulate was described by as student:

*“So...you can see how he [clinical supervisor] interacts with the patients...you can...learn from what he’s doing”*

The student felt that observing the clinical supervisor engaging in clinical care would assist him in rendering care. This would be supportive as the student would know how to interact with patients; consequently it would have a positive effect on the emotional experience. Role modelling was not limited to clinical supervisors but also to University of the Western Cape graduates who are perceived to be successful:

*“Every time I...see a person who previously studied in Udubs (The University of the Western Cape) who has done things that I could see with my eye. ...who’s changed in his life, in his parent’s life. I...see myself as that person who can make a change in the life of my family,...friends...”*

Roles models are important as they give hope to students. Positive outcomes such



as described above appeared to make the experience less distressing, as the students could focus on the outcome rather than the process of their experience. In addition to having role models, supportive interventions also needed to be formalised.

A formalised approach to the supportive interventions would be the institution of a counselling programme specifically for nurses. The programme would include continuous weekly debriefing sessions managed by four counsellors who would service students in specific study year levels, for example a counsellor for year level one and so on:

*"If... we get counselling from the university..."*

*"create...counselling only for nurses"*

*"... debriefing sessions..."*

*"a session...within your week, where you...can... vent or explore what you've been feeling. Or telling, talking, sharing..."*

*"the support... should be an on-going thing..."*

*"...our own support service in the department of nursing, just for nurses, because we go through different traumatic experiences that need counselling"*

*"...there must be four counsellors who are divided in each level"*

The participants were very specific about the pertinent counselling needs for nursing students, as they may have experienced a range of distressing events in the unsupportive environment of the mental health care settings. Students may feel less traumatised if they knew that they could access support which was tailored around their specific emotional support needs when they needed it.

#### **4.2.4.2 Students emotional support needs relating to the mental health care setting**

**Theme 9A: Effective collaboration between HEI and clinical service to ensure that there are clear policies and procedures in place to support students. Mentoring programmes and counselling with involved staff to support students in the mental health care setting.**

Liaison between the HEI and mental health care setting was deemed important in establishing an effective relationship, which would support students in the mental health care setting:

*“I think like there should be a more effective relationship between the university and all the placements where they place the students”*

It was evident that students felt that effective communication between the HEI and the clinical settings would lead to all parties knowing the expectations of the other; students would benefit from the communication as they would feel supported in the mental health care setting. Curtis (2007) conducted a study in Australia on a collaborative teaching approach by academics and clinicians, on preparing undergraduate nursing students to work in mental health care settings. This approach consisted of intensive clinical workshops to prepare the students for the placements. Results from the study indicated that students felt better prepared and more confident to work in mental health care settings. They saw the academics (educators) and clinicians (clinical staff) working together. Clinicians felt that both the students and academics valued their knowledge and skills. Students' felts less alienated, as the clinical staff were more welcoming and supportive of them in the clinical setting.

Communication would include having clear guidelines and communicating it to students, so that they know what to expect when they are at the mental health care settings:

*“...clear guidelines...before going to facilities to know what is happening there”*

In addition, students felt that they needed to visit the psychiatric hospitals prior to the placements, so that they would know what to expect when they were placed there.

*“...beginning of the year...take us [students] to the places [mental health care settings]... show us...the kind of people [mentally ill patients] that you [students]are going to work with”*

*“Take the students there [mental health care setting], let they can [them] experience...”*

The clinical facility site visit may alleviate the fear which may have arisen from not knowing what to expect, the stories heard about mentally ill patients and the stigma attached to being mentally ill. Moreover, it was also deemed important to hold programmes with individuals to alleviate the adverse emotional experiences.

The students identified mentorship programmes and mentors to support students in the setting.

*“...have mentorship programs”*

*“...in the wards...be...a mentor...who orientated you on the first day”*

It appears that students felt that formalising mentorship programmes would mean that mentors would be available to orientate them to the mental health care environment and thus be available for support.

Students also felt that clinical staff should be involved to educate them as this would be supportive:

*“...more involvement from the unit manager and from the staff...”*

*“Being... involved with us, in the process”*

*“... is important for the registered nurses to educate their junior students”*

*“...using that extra time to discuss or educate us.*

When students are placed in mental health care settings, the assumption is that they will be educated by the clinical staff, as they need to attain the clinical learning objectives for the nursing programme. It would appear that clinical staff involvement and education of students may be limited, hence the students identifying the need.

Other support needs included accessibility of emotional support via telecommunication, for example students must be able to telephone a student support line to access supportive counselling when they needed it to cope with the emotional experience. Furthermore, students felt that if there was a system for them to make appointments to see the counsellors when they are distressed, they would be supported:

*“lifeline...that you can...phone...”*

*“...system of booking...the counsellor”*

Some students felt engaging in self-care activities such as pampering days would also be supportive:

*“I think we can also have pampering days. Maybe once a month just for us to relax psychologically and also to prevent burnout”*

Students felt that student support services need to be available to them at the clinical settings. If it is in close proximity it would provide available and accessible support, such as counselling for students who were emotionally distressed:

*“...if...there was services...for students inside the hospital settings, that would be better”*

### 4.3 SECTION TWO: RESULTS OF EDUCATORS AND CLINICAL STAFF

The presented semi-structured interview results of educators and clinical staff address the following objectives:

- To explore how educators and clinical staff perceive student coping in the mental health care setting, as a means of establishing their views of the students' emotional challenges in the mental health care.
- To describe the strategies which education and clinical staff use to support students working in a mental health care.
- To identify students' emotional support needs

The following research questions were asked to attain the aforementioned objectives:

- *What emotional issues, that you are aware of, do students have to cope with whilst working in the mental health care setting?*
- *How do you support students working in mental health care settings?*
- *What existing support services are in place to support students emotionally?*
- *What would you suggest that the SoN put in place to support students who work in mental health care settings?*
- *What would you suggest that the clinical services put in place to support students in this emotionally challenging environment?*

The same set of questions was posed to both educators and clinical staff. The results are presented separately, for each group to capture the similarities and differences of the perceptions for each group.

#### 4.3.1 Educators perceptions of students' emotional responses

**Table 4.4: Themes and categories of educators' perceptions of students working in mental health care settings**

THEMES	CATEGORIES
<p><b>Organisational</b></p> <p><b>1B:</b> Availability of ward staff and clinical supervisors to support students, were contradicted by reports of negative staff attitude and lack of support for students. Poor communication, lack of support from the HEI, as well as students' lack of preparation and their distrust of clinical staff and educators - impacted negatively on the students' emotional experience.</p>	<p>Poor student behaviour resulted in clinical staff being negative towards students and not taking responsibility to supervise students, despite students being regarded as workforce, resulting in an adverse emotional experience for students</p>
	<p>Educators regarded the support of the occupational and ward staff as being available to support students</p>
	<p>The educators experienced frustration at the lack of support for students from the colleagues (lecturers) at the HEI, which impacted negatively on the students' emotional experience</p>
	<p>Communication between educators was lacking, thus impacting negatively on the support given to students</p>
	<p>Students were ill-prepared to care for intellectually disabled patients because they lacked exposure due to their upbringing</p>
	<p>Educators indicated that lack of trust in clinical staff by students resulted in non-verbalization of students issues</p>
	<p>Initially students experienced distrust of educators based on unfamiliarity with them</p>

<p><b>Psychological</b></p> <p><b>2B:</b> Students' experience of the mental health care environment resulted in adverse emotional symptoms. An increase in the students' knowledge of psychiatry led to self-diagnoses and presentation of clinical symptoms of psychiatric illness, as they identified with the patient's histories.</p>	<p>Students experienced the mental health care environment as draining, frightening, shocking, and anxiety provoking, due to the nature of the work and the patient's condition</p>
	<p>Educators felt that identifying with patients' histories evoked personal issues in the students, resulting in emotional distress</p>
	<p>When students gained knowledge in psychiatric nursing, they diagnosed themselves or presented with clinical diagnoses</p>

**Theme 1B: Availability of ward staff and clinical supervisors to support students were contradicted by reports of negative staff attitude and lack of support for students. Poor communication, lack of support from the HEI, as well as students' lack of preparation and their distrust of clinical staff and educators impacted negatively on their emotional experience.**

Educators reported that the clinical staff displayed a negative attitude towards students due to poor student behaviour. Students were ridiculed and ignored when their behaviour was perceived to be undesirable:

*"...staff finding that... students don't know how to conduct themselves... and the staff were shouting...or belittling them"*

*"they just ignore the students"*

Educators also felt that the clinical staff did not understand that it was their responsibility to support and supervise students. This perception appeared to be based on clinical staff being conversant with student issues but not informing the educators or managing the issues:

*“the nursing staff...I don't think they see it as their role to support the students...because every time they pick up something, they ...tell you nothing. They do nothing about it”*

*“The sister don't (doesn't)...supervise students. Students are doing things on their own”*

Educators felt that despite the negative attitude clinical staff displayed towards the students, they were regarded as part of the workforce in the mental health care setting:

*“...they take the students as a working force, an extra hand to assist them”*

*“The students are there as work force”*

Given the shortage of nurses, it was not surprising that students were seen as part of the work force in the mental health care setting. Nevertheless, the educators had identified specific clinical staff that was supportive of the students in the mental health care setting:

*“they go to occupational health. There's a sister...there and she's very open with the students so most of the time they'll go there”*

*“...every time the student arrives...this person (the student coordinator) will explain everything...will explain if they don't feel comfortable...they are free to contact her...”*

The educators identified the occupational health nurse and the student coordinator at the various mental health facilities as the individuals who provided support to distressed students. The job descriptions of these identified individuals was staff and student support, hence the expectation that they would be the key people providing student support at the various mental health facilities.

The educators experienced frustration at the lack of support for students from the HEI, which impacted negatively on the students' emotional experience:



*"I even ask psychologist or psychology department. I was referred to them... I couldn't get anyone one to assist..."*

*"there was a student. He was...going through a crisis with a sister....(who)...was rape (raped)...It was quite frustrating because you can't get...who to talk to and ...it end up...you... carrying this load that you ...want to give to someone else.*

The educator described the feeling of being emotionally burdened by supporting a student through an emotional crisis. Support from the HEI was deemed to be unavailable. It is evident that educators perceive their role to include providing support to students. However, this role is compromised when support structures to whom referral is necessary is unavailable. The educators themselves feel burdened, which may have an adverse effect on the students' emotional experience. This is especially true when communication between educators is lacking:

*"...where's our [educators] communication channels?... It's not that it must be confidential. We [educators] must all know what's...happening to a student"*



The educators, specifically the clinical supervisors, referred to the lack of communication and the importance of being familiar with students' emotional needs. Whilst educators (clinical supervisors) reported student emotional issues to the lecturers, they were not given feedback about the students nor were they informed whether students were ill as is evident by the following quotations:

*"By chance we'll hear about the student that's sick"*

*"...that is the type of student that...needs follow up...But...if I reported it...it just ends there. I'll never hear a thing...unless I deal with the student..."*

Educators (clinical supervisors) can support students but only if and when they are aware of their support needs, hence the importance of all educators being informed about student emotional support needs. The uncertainty of not knowing what had

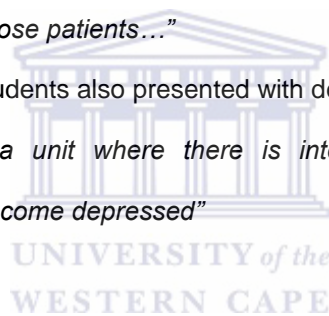
transpired after the educator (clinical supervisor) had referred the student, poses a challenge for the educators (clinical supervisor) who perceive their role as being supportive to students.

In addition to the emotional issues experienced, educators reported that students were ill-prepared to work with intellectually disabled patients. Students were emotionally traumatised by the extent of the deformity of intellectually disabled patients and by having to care for them:

*“...on the IDS side, it’s emotional shocking because...you see from the deformity, the disability...something that you never thought there is somebody like that on earth...they...scared of ...touching those patients...”*

The educators maintained that the students also presented with depression:

*“if they [students] are going to...a unit where there is intellectually disabled persons...some people [students] become depressed”*



The educators felt that students’ unpreparedness for the direct realities of caring for intellectually disabled patients was due to the students’ background regarding non-exposure to intellectually disabled patients:

*“in our black communities... ID patients... (are) kept inside the house... they (students) are not used to see (seeing)... and interact (interacting) with them”*

The above was perceived to be peculiar to Black nursing students. In this study, however, students from other ethnic groups also confirmed the trauma experienced whilst caring for intellectually disabled patients, as they had also not been exposed to them during their upbringing. In mental health care settings, the expectation would be that both educators and clinical staff are responsible for ensuring that students are prepared to care for intellectually disabled patients.

While educators may have observed signs and symptoms of emotional trauma in students, they reported that students distrusted both them and the clinical staff. Educators' stated that students did not disclose or verbalise their emotional issues to the clinical staff as they did not trust them, which resulted in students not being supported by the clinical staff:

*"...they don't...know what's the problem...because students don't open up to them"  
They'll...stay out of work and (say) I didn't have money. In the meantime she's in an abusive relationship and she couldn't come to work...they don't tell the sisters (registered nurses) this type of thing. They not very much involved. ...the students are... there...to meet the objectives of the course..."*

It is not surprising that educators see students to be distrustful of clinical staff, as they felt that there was minimal clinical staff involvement with the students and an unsupportive mental health care environment. The distrust was not only directed at the clinical staff, educators alleged that initially the students distrusted them too. The distrust was a result of the students not knowing them:

*"they [students] don't open up in the first place because we still knew to each other. We don't know each other...as I follow them up, they'll start...trusting me and confide in me..."*

The students knew the educators as they had been at the university for three years prior to their psychiatric placement. Educators are visible at the various hospitals where students are placed, it would therefore be expected that students encounter educators during their three years of study and thus be known to each other.

**Theme 2B: Students' experience of the mental health care environment resulting in adverse emotional symptoms. An increase in students' knowledge**

**of psychiatry led to self-diagnoses and presentation of clinical symptoms of psychiatric illness, as they identified with the patients' histories.**

Educators observed that students were fearful and anxious while working in mental health care settings. Fear and anxiety were largely due to students never having been exposed to mentally ill patients:

*"students...are scared of...psychiatry because...they've never been exposed to it before...it's very frightening"*

*"...students are very anxious....because it will be their first time at a mental health facility...they experience a lot of anxiety"*

The fear and anxiety experienced by students and perceived by educators were related to the unpredictability and propensity for violence of mentally ill patients:

*"...they ...scared of the...acute side...because they think they going to be harmed or...in danger because of the unpredictable [unpredictability] of the patient"*

The perception that mentally ill patients are violent, seem to be held by educators who themselves may project their own anxiety about the mental health care environment on the students. This may be exacerbated by the educators' unfamiliarity with the patient population in the mental health care settings, as their role is student supervision and not patient care.

In addition, educators reported that the mental health experience was emotionally draining and distressing for students:

*"...mental health is draining. I think...it's very emotional if you are not emotionally strong..."*

The emotionally draining experience was especially true for vulnerable students, according to educators. Educators felt that students needed to be "emotionally

strong” to be able to work in the mental health care settings. Though being emotionally strong was not interrogated during the interview, in this study educators refer to students who have coped despite adversity in life - hence the assumption that students who have coped despite adversity would be considered to be emotionally strong.

The educators felt that as students gained knowledge about psychiatric illnesses, they identified signs and symptoms within themselves, which resulted in self-diagnosis. However the students' behaviour may be defence mechanisms rather than actual diagnosis. This statement was not interrogated.

*“...when they come to personality disorders, they... diagnose themselves”*

Students may identify personality traits within themselves when learning about personality disorders. The personality traits may be translated into personality disorders as they have limited knowledge and clinical experience in psychiatric nursing. Students may also present with clinical diagnosis as was illustrated by the educators who reported:

*“...quite a few students...became depressive during...fourth year. ...I don't know if it was the clinical setting...the work load...the full week...but allot of them...told me that...that everything's too much for them. They want to give up. They can't cope with everything.*

*“...I have a student that has been for rehabilitation for alcohol [abuse]”*

While the educator acknowledges that there are various reasons for students presenting with a clinical diagnosis of mental illness, educators perceive that the inability to cope with the mental health experience appears to be significant. One of

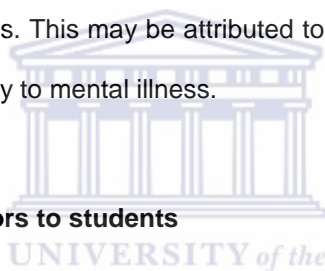
the reasons cited according to educators, may be that students identified with patients' histories:

*"...I think what makes it worse is the fact that they [students] now work with mental health patients...they [students] ...identify with what they are working with and their own stressors"*

Patient histories evoked personal issues in the students which resulted in emotional distress:

*"...there's people with low self-esteem [self-esteem]...she [the student] can see their own symptoms and...doesn't know how to handle them...she just breaks down"*

Educators felt that students were unable to detach themselves from patients who presented with similar trauma histories. This may be attributed to students becoming knowledgeable about their vulnerability to mental illness.



#### 4.3.2 Support provided by educators to students

**Table 4.5: Themes and categories of support provided by educators to students**

THEME	CATEGORIES
<p><b>3B:</b> Availability for individual student consultation and role modelling, constructive communication skills to ascertain student coping and to assist them to cope in the mental health care setting</p>	<p>Educators make themselves available to students for one-on-one consultations which students prefer, and the educator shares their own experiences to show that they understand.</p>
	<p>Educators listen to the students, they enquire whether students are coping and motivate them, and they use empathy in trying to assist students to cope with the experience</p>
	<p>Inquire about wellbeing to ensure that students felt supported</p>

	Educators referred students to the student support services
	Liaison between colleagues to raise awareness of students in need
	Creating a peer support system and allowing self-exploration allowed students to rely on each other strengths and increase their confidence
	Educators encouraged students to use discretion when identifying role models to cope with the emotional experience

**Theme 3B: Availability for individual student consultation and role modelling, constructive communication skills to ascertain student coping and to assist them to cope in the mental health care setting**

Communication was significant in developing and sustaining interpersonal relationships between the educators and students. Various communication mechanisms were employed by educators, which aimed at providing support to students in the mental health care settings. Educators reported that they made themselves available for individual consultations to support students to deal with the emotional experience:

*“...avail ourselves...as academics... and...clinical supervisors”*

*“when you see them one-on-one, they usually more open”*

*“...if students are really distressed, they...come and see us individually...they would...come to your office to talk about it privately and then we support the students”*

It appeared that distressed students felt more comfortable to consult with educators

on an individual basis. Educators on the other hand shared their own clinical experience to communicate to the students that they understood the students' distress as an educator reported:

*"...make examples of a reality of the real psychiatric nursing"*

Communication also included listening with empathy to support students, as was reported by educators who said:

*"...I listen to them"*

*"...I put myself in their shoes...to help them"*

Listening is important in an interpersonal relationship, as it may convey to the students that the educator understands that their emotional issues are significant. Students may feel supported. In addition, students were also afforded time during the classroom session, to discuss their experiences and to be motivated to comprehend the difference they were effecting in the lives of patients, as was reported by educators:

*"... time... in class so that students can reflect on their clinical experiences. Then we have discussions about it"*

*"...I... motivate them to say you are making a difference..."*

Educators reported inquiring about students' wellbeing to ensure that students felt supported in the mental health care environment as is illustrated by the following quotations:

*"You will ask them, how you are doing? Are you coping here [in mental health care setting]?"*

*"...I phone them [and ask], How are you coping? How the [are] things?" They are appreciating it because they... say... sometimes I feel like [I need] somebody to talk to"*



It appears that students value the educator's interest in their emotional wellbeing, as it is deemed to be supportive. Valuing by students is evident in educators perception that support is appreciated. Educators reported liaising with their colleagues to ensure that at-risk students were identified and supported:

*"we also inform the clinical supervisor...so that they're... aware of individual students that need additional support"*

It is evident that educators created a system where the relevant people who were involved in student supervision were kept informed of vulnerable students. Some educators created a peer support system:

*"I've met students who are very strong irrespective of what circumstances they coming from...those are the students I use... ..combine them and... I keep them together..."*

Educators also encouraged self-exploration, so that students could familiarise themselves with the ward environment:

*"I will leave you today...when I come back...I'm expecting you to tell me what's going on in the ward"*

These actions of the educators occurred, to permit students the opportunity to rely on each other strengths and to increase their confidence.

Whereas some clinical staff may have been perceived as role models for students, the educators encouraged students to be discrete when identifying role models in the clinical setting:

*"...turn a blind eye because that one [professional nurse] is not showing you the right way...it's entirely (up) to you what you want to learn"*

*"Don't look at those who are already qualified"*

Students were encouraged by educators to “turn a blind eye” to the untoward clinical staff actions and behaviour. Learning in the mental health clinical setting was assumed to be entirely the students’ responsibility, as there did not appear to be role models whom the students could emulate. It is evident given the educators’ response that student may be traumatised, that they are novices who are expected to learn and be supported by the clinical staff in the mental health care settings. To deal with the trauma, educators informed the students to access the student support services at the university:

*“I always tell them go to the student centre”*

The researcher is of the opinion that ‘telling’ students to seek help, instead of assisting traumatised students to access support by making the necessary referrals is counterproductive. Students may not have the inner resources to access support and may therefore require the educator to assume temporary responsibility for accessing the necessary support. It has been noted that the educator refers students to the ‘student centre’, which at the University of the Western Cape is commonly the area where students gather for entertainment, food and generally to relax. Students needing support are usually referred to the student support services, which is widely advertised at the university.

#### 4.3.3 Support needs of students as perceived by educators

**Table 4.6: Themes and categories of student support needs as perceived by educators**

THEMES	CATEGORIES
<p><b>Support services</b></p> <p><b>4B:</b> Educators were unaware of structured student support services but identified informal support within the HEI and clinical services</p>	<p>Educators were unaware of structured support services</p> <p>Educators identified their role, the clinical services and residence committees in</p>

	providing student support, albeit informally
<b>HEI</b> <b>5B:</b> A multidisciplinary team approach, with staff from the HEI rendering a structured programme for nurses with access to resources, was identified.	← Educators identified an independent department and structured programme for student support
	← Educators identified an available nurse with knowledge, skills and attitude to assist students to deal with the emotional experience
	← Access to available support via telecommunication was deemed supportive for student support
	← A multidisciplinary team approach to support students, was identified
<b>CLINICAL</b> <b>6B:</b> Liaison between the HEI and clinical service and training by clinical staff to take ownership of their role in the supervision of students in the mental health care setting.	← Liaison between the HEI and services, to ensure services taking ownership of students
	← Educators felt that clinical staff needed training to fulfil their supervisory role

**Theme 4B: Educators were unaware of structured student support services but identified informal support within the HEI and clinical services**

Educators reported that they were unaware of structured support services for students:

*“...I’m not aware of structured support systems that is more readily available”*

Although they may have been aware of the student support services at the university, educators may have perceived these services to be unavailable when students needed them. As an alternative, educators identified the role that they play in supporting students:

*“...do a bit of counselling...to find out if there’s any support group or anyone at home who supports them”*

*“lecturers... attend to students and support them”*

The role identified by educators included limited counselling, which appeared to be focused on information gathering regarding support structures which students could access.

Educators felt that the professional nurse in charge (matron) did provide some support to students, albeit informally:

*“They do have support opportunities where students can go to the matron’s office...”*

Students living at the university residences were also being supported by the residence committees, which appeared to have a range of interventions aimed at student emotional support:

*“Each residence got a residence committee and each residence has got a warden. ...They attend to students with emotional problems such as loneliness, isolation, depression. Even...alcohol and drug problems; they handle... and refer...”*

The extent of the interventions appeared to be referral of the students after assessment.

#### **4.3.3.1 Support needs of students as perceived by educators relating to the HEI**

##### **Theme 5B: A multidisciplinary team approach with staff from the HEI rendering a structured programme for nurses with access to resources was identified**

Educators identified resources, such as a student support centre offering a structured programme, for student support. Individuals who offered the services may have been

the available educators who were tasked with student support. They felt that there should be a person from each year level in the nursing programme, which would render the support service:

*“department on its own where there’s people working with these [this] type of experience to support students , you know to refer, even counsel”*

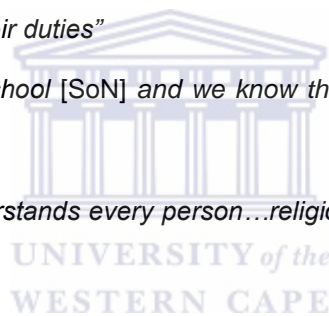
*“...we have all the expertise here [at the university] so...we can...have a more structured programme for student support...”*

*“...something specifically for nursing students at our school...”*

*“There should be someone at the school...if they can’t appoint someone new then ...from each year level there must be one person that not have that as their responsibility but have that part of their duties”*

*“Somebody...permanently for the school [SoN] and we know that person would be reliable”*

*“diversed [diverse] person who understands every person...religion...accommodates everything*



The person who is identified should have the characteristics of reliability, be accommodating and amenable to a transcultural approach to support. It would appear that the educators felt that emotional support for nurses should be specific to nurses. The individual should also have undergone specific training to render the support service:

*“...a nurse but has undergone an advanced counselling course”*

Training in advanced counselling skills may be perceived by educators, as having expert knowledge to render support to students. However, another educator felt that a team approach to student emotional support was needed:

*“here’s all the departments...on campus so if we can...have a group...the multidisciplinary team for our students...”*

Referral to ‘*all the departments ...on campus*’ may be interpreted as having departments such as psychology, social work and nursing from which individuals could be identified, as a multidisciplinary team offering emotional support to student nurses. Another educator perceived utilising existing support, namely clinical supervisors with strong human qualities:

*“...clinical supervisors to be more supportive, more caring towards the students, more teaching and where they feel that students are weak, just to give them more attention”*

In addition to departments, programmes and human resources, instrumental support was also identified by educators:

*“...like life line, chat line where you call...”*

*“We give them our numbers on the first day at the institution*

*“...give all the students when they starting...this questionnaire who will be in need or assisted in anything emotionally...”*

Educators identified the use of telecommunication as a supportive intervention. Students would be able to access support when and if they needed it. Some students who did not feel comfortable talking to others, for fear of judgement, may feel free to access telephone support. Students may also communicate existing support needs, which would enable educators and clinical staff to offer the appropriate support to students.

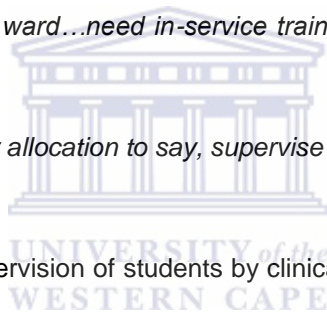
#### **4.3.3.2 Support needs of students as perceived by educators relating to the mental health care setting**

**Theme 6B: Liaison between the HEI and clinical services and training by clinical staff to take ownership of their role in the supervision of students in the mental health care setting students, facilitated by the liaison between HEI and clinical services.**

Educators felt that clinical staff required training to fulfil their role in supervising students. Clinical staff also needed to be assigned, as part of their daily tasks; to supervise students who were placed in the wards, as is highlighted by the educators who reported:

*“for me...anybody who’s running the ward...need in-service trainings for their role... for teaching and learning”*

*“When they [clinical staff] do the duty allocation to say, supervise the students”*



Educators may have felt that the supervision of students by clinical staff is important, as students are placed in the mental health care settings in order to acquire knowledge, attitude and skills. If clinical staff is formally tasked with student supervision, the assumption is that they may identify it as their role. Students may feel that they are part of the mental service, as their support needs would also be addressed by the clinical staff.

However there needs to be liaison between the HEI and services for clinical staff , to take responsibility for the students that are placed in the mental health care setting:

*“I think there should be a relationship...between the university... school of nursing and the facility so that the facility will take ownership of ...the student”*

Collaboration between HEI's and clinical services may ensure that student support is coordinated, so that all role players are informed about support structures and referral pathways to name but a few.

The following three tables depict the results of the semi-structured interviews of the clinical staff participants.

#### 4.3.4 Clinical staffs' perceptions of students' emotional responses

**Table 4.7: Themes and categories of clinical staffs' perception of students working in mental health care settings**

THEMES	CATEGORIES
<p><b>Organisational</b></p> <p><b>1C:</b> Positive staff attitudes and role modelling were limited, however to a large extent the workload, clinical environment and negative attitudes of staff and lack of role modelling impacted negatively on the students' emotional experience</p>	Work overload has a negative effect as students are unable to meet their own learning needs
	Negative staff attitude had an impact on the emotional experience
	The staff's positive attitude had an affirming effect on the students' emotional experience in the mental health care setting
	The type of ward that students were placed in and the lack of role models had a negative emotional effect on students
<p><b>Sociological</b></p> <p><b>2C:</b> Students' socio-cultural background, family responsibilities and family expectations regarding the students' role as a nurse within the family, had an impact on their emotional experience</p>	The students' response and understanding of mental health was influenced by their background, which impacted on their emotional experience
	The students' family responsibilities and family expectations in regard to the student as a nurse, had an impact on their emotional experience



<p><b>Psychological</b></p> <p><b>3C:</b> Processing of the mental health experience heightened the students' self-awareness, uncovering their own unresolved issues which were projected either positively or as non-verbalization, emotionally draining, traumatic and alarming.</p>	Working in a mental health care environment increased the students' self-awareness
	Lack of trust and confidence in clinical staff resulted in non-verbalization of experiences
	Students identified with the patients' histories and diagnosis which uncovered their own unresolved issues
	Working in the mental health care environment was emotionally draining and traumatic
<p><b>4C:</b> Fear and anxiety related to the negative stories and stigma about psychiatric patients, negative patient behaviour and students' lack of knowledge to manage these behaviours</p>	Working with intellectually disabled patients was distressing for the students
	Stigma and negative stories about psychiatric patients conjured up feelings of fear and uncertainty
	Students displayed fear was related to the patients' physical and verbal aggression and intimidation
	The students' experienced anxiety due to their lack of knowledge and readiness to manage the patients' symptoms

**Theme 1C: Positive staff attitudes and role modelling were limited; to a large extent the workload, clinical environment and negative attitudes of staff and the lack of role modelling impacted negatively on the students' emotional experience**

Clinical staff acknowledged that students were used as part of the workforce in the mental health care setting. Students received no preferential treatment to ensure that

they were able to meet the learning objectives, as their workload was the same as that of the clinical staff:

*"They work as hard as we do"*

*"Students are really part of the workforce. Many a time they can't even do ...what they have to. They get taken out of the ward where there is no staff nurse..."*

Work overload has a negative effect, as students are unable to meet their own learning needs. Mabuda et al (2008) study concurs with these findings, as the participants learning needs or their student status was unrecognised as they were seen as workforce or a ' pair of hands' in the wards. Whereas the above situation appears to be the norm in many public hospitals due to the chronic shortage of nurses, students' emotional wellbeing is being compromised due to the unrealistic expectations of the clinical staff. Students are faced with many challenges; they have to complete the clinical requirements of the nursing programme besides having to render care to mentally ill patients in an unsupportive environment. It is no surprise that students have a negative perception of the mental health care environment.

The type of wards that the students were placed in also contributed to the negative emotional experience, as a staff member reported:

*"The ward... it affects them emotionally too"*

Students may be ill-prepared for the mental health care environment, which in turn may lead them to perceive it to be unsupportive. This perception is further affirmed by the staff's negative attitude towards the students, which then has an impact on the students' emotional experience:

*"They [students] probably feel that they are probably not well supported. The professional nurses come across as...domineering ...unkind..."*

*“...there are those [students] who...feel intimidated or... scared by some of the professional nurses”*

In addition, role models in the mental health care environment were limited. Although specific staff members were identified as role models, there were a shortage of professional nurses for students to emulate and this was reiterated by clinical staff members:

*“There are not a lot of Mr [X]....around”*

*“... lack of role models”*

Despite the negative attitude of clinical staff and limited role models, there were clinical staff reported as displaying a positive attitude towards students. This was perceived to have an affirming effect on the students' emotional experience, which was construed as students having a positive mental health experience. Staff reported:

*“...a lot of them have a lot of positive experiences...when they feel that they are part of the team. When they feel that their feedback is valued...that's a very validating experience for them. That is often the feedback that we get”*

*“...there are very supportive staff members... like Sister...She has just got a thing for students...the feedback from the students are all very positive for her”*

*“....the ones...who are student orientated... will try and make time for the students”*

Specific clinical staff members were acknowledged for their role in supporting students in the mental health care environment, quotations such as *“She has just got a thing for students”* and *“the ones...who are student orientated”* being voiced by the participants in the study in support of the identified staff members.

**Theme 2C: Students' socio-cultural background, family responsibilities and family expectations regarding the students' role as a nurse within the family, had an impact on their emotional experience**

Clinical staff recognised the students' response and understanding of mental health to be influenced by their background, which impacted on their emotional experience

A participant likened the impact that the lack of exposure to mentally ill patients had on students' emotional experience as *"cultural shock"*:

*"...it is more about the cultural shock. Never been exposed..."*

Students' cultural background also influenced the manner in which they communicated their emotions. Specific reference was made by the participants (a Black male and female) to Black South African students, who were reared to suppress their emotions as illustrated by the following quotations: .

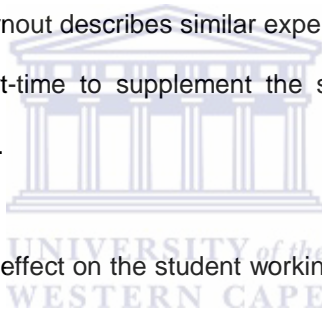
*"...when it comes to African people...some of them maybe not easily verbalise their emotions...they will keep to themselves than to openly talk"*

*"...cultural, there's a lot of people [students] who are not open to talk when they come to us. Children must be seen but not heard"*

The aforementioned did not appear to deter students from seeking the support of the clinical staff when they felt that besides their emotional experience, they were also distressed by their family's expectations of them as nurses:

*"...many often...come...and tell me about their personal background,...challenges at home, seeing that they are student nurses... the family tell...everybody put everything on them... to the family they [students] come someone who's going to help us. And their expectations are so much"*

The participant felt that the expectations were excessive and therefore impacted on the student's emotional experience. Students were also expected to fulfil their roles as parents and breadwinners. Although some students received bursaries to study at the university, the amount of this financial assistance was inadequate to meet the family's needs, as students' study obligations were met first. The funds were administered by the university upon receipt thereof from the Department of Health, in the Western Cape. The students received the balance of the funds after the study fees were deducted. The expectation was that they would purchase study material with it. As a result, most students had to work at least part-time, in addition to their studies, to remain self-supporting during their education and training. Rella, Winwood & Lushington (2009) in a study on burnout describes similar experiences of university students in Australia, who work part-time to supplement the support grants they receive from the Federal Government.



A clinical staff member describes the effect on the student working to generate funds in order to fulfil the financial responsibilities to the family, as being too tired to care for patients and falling asleep on duty:

*"We get students whose children are sick...There was families...a student who said.....when he is off, he must go and work...he must look after his people...he cannot survive on his bursary money alone. He is tired. The problem was...he was sleeping...it was reported..."*

In addition to the emotional distress that students experienced working in the mental health care setting, they were also burdened by social stressors such as lack of finance, which may have exacerbated the negative experience illustrated regarding the student falling asleep on duty.

**Theme 3C: The processing of the mental health experience heightened the students' self-awareness, uncovering their own unresolved issues which were projected either positively or as non-verbalization, emotionally draining, traumatic and alarming**

Clinical staff reported that self-awareness in students increased when they worked in mental health care settings. The self-awareness resulted in students being emotionally vulnerable, as illustrated by the following quotation:

*"...they [students] are emotionally very...vulnerable"*

The emotional vulnerability may stem from students identifying with the patients' histories and presenting with clinical diagnoses. Students' unresolved issues were uncovered during the process:

*"...most of them grew up similarly like the presentation [discussion of patient history]. You can sit in a presentation and...find it is the person who grew up in a rural area, had the same issues...who...never worked through their issues of emotionally"*

*"...some...would... say that someone in their family have that [mental illness]. That is another emotional burden on them, especially in mental health"*

*"they would tell me... they have certain problems... they're under [receiving] medication for depression..."*

It would appear that the participants felt that the students' distress was related to the discovery that patients had endured similar emotional issues as they had but developed a mental illness. The stigma and uncertainty of mental illness may have produced fear in the students, as they realised that they too have a susceptibility to become mentally ill.

Despite the emotional trauma that the participants felt students experienced, they reported that some students lacked trust and confidence in clinical staff. The result

thereof was that students did not verbalize their negative experiences to the clinical staff:

*“...I don’t...have...complaints from students. If they are unhappy, we don’t hear it”*

*“Some of them... don’t trust you... enough to say, this is the story”*

*“...some of them are just not open to talk about it. If they see a problem they cannot be confident enough...”*

Clinical staff felt that students experienced the mental health care environment as emotionally draining and traumatic:

*“mentally it’s draining working in the hospital or at a mental health clinic... academic experience...is also draining...is like creating a time-bomb that can explode at any given time. Sometimes the student may just act out...”*

The participants also felt that the academic experience was draining. The clinical and academic experience was equated with a ‘time-bomb’, which may be interpreted as destructive and dangerous. The participant describes the unpredictability associated with how students react or respond to the distress experienced.

Despite the mental health experience being distressing due to an increase in the students’ self-awareness, not trusting the clinical staff and it emotionally draining - the participants felt that students were burdened by other issues as well:

*“...they are carrying a lot”*

It is evident that the participants felt that the students to be emotionally distressed by a range of factors which appear to be exacerbated by the mental health experience.

**Theme 4C: Fear and anxiety in students related to negative stories and stigma attached to psychiatric patients, negative patient behaviour, intellectual**

**disabled patients, and the students' lack of knowledge and readiness to manage the patients' behaviour**

The participants claimed that the students experienced feelings of fear and anxiety related to the uncertainty of not knowing what to expect from psychiatric patients and the fear of the unknown. Some clinical staff reported:

*".....if they [students] come in psychiatry they are afraid. Colleagues told them all sorts of stories so they are scared. It is usually... of the unknown"*

*"...fear of the unknown. They've heard horror stories about psychiatric patients... I think it is more the fear of being attacked by a mentally ill patient"*

It appeared that most of what they had heard about mental health was negative, for example the violence which generated considerable fear. Students may also have entered the mental health care environment with preconceived ideas about mentally ill patients. Participants reported that the students were informed about the mental health care setting by colleagues who focused on the negative aspects of mental illness, which formed a stigma as illustrated by the following quotation:

*"... most of them [students] will come with a stigma related towards it [mental health]... When working with outside or fellow colleagues in the fourth year, some of them [colleagues] give them [students] negative feedback about mental health"*

The negative stories became a reality when students experienced physical and verbal aggression as well as intimidation from the patients in the mental health care setting:

*"... the patient pushed the student...in high care, floridly psychotic...she was very tearful when she came to relate it to me afterwards"*

*"...they [students] work in wards with aggressive patients. Sometimes they ... get assaulted by the patients...There are those [students] where spectacles were broken by the patients"*



*“here’s a lot of swearing of patients...they don’t know if we are students or a professional. Some of ...what they swear... is not nice what you hear”*

*“...the clients [patients] can... see when they [students] are scared. Patients are so good... they...know when they... intimidate you...they...know that you are uncomfortable in their presence...”*

Verbal abuse or swearing, according to Stone and Hazelton (2008), by patients leaves students shocked and render them uncertain on how to respond. Furthermore, students were faced with caring for intellectually disabled patients which was acknowledged by the participants to be traumatic for students who were unfamiliar with intellectual disability:

*“emotionally they are really hurt to see the clients that are intellectually disabled... some of them 100% dependent ... on other people for their activities of daily living”*

*“...we are dealing with people with intellectual disability... our patients although they are big enough but their mind is [small]... they [students] are not used to that...it is... shocking to them.*

The participants admitted that students faced the emotional challenge of dealing with negative behaviour and intellectually disabled patients without knowing how to manage the patients’ symptoms because they lacked the knowledge and skills:

*“...the two things that are the worst for them. What do I do when a patient becomes aggressive? How must I handle it? What can I do if the patient tries to commit suicide? I don’t know what to do”*

*“Not knowing how to handle the patient. Not knowing...if they’re going to say something that it is going to trigger the patient’s anger or aggression”*

*“...students were...traumatised because they’re supposed to know a little and they*

*get very worried. Unless you go sit and you explain that all to them then ... it is very stressful for them.*

Clinical staff reported on their comprehension of the various reasons for students being traumatised in the mental health care setting. These include fear of the unknown, and acts of violence and intimidation - which became a reality when students were abused by patients. Then there are the students' expectations of what they should know to be able to care for mentally ill patients when they are placed at the mental health care settings.

#### 4.3.5 Support provided by clinical staff to students

**Table 4.8: Themes and categories of support provided by clinical staff to students**

THEMES	CATEGORIES
<p><b>5C:</b> Sharing own experiences and availing themselves in a professional relationship, clinical staff engaged with and reassured students to allay fears and increase students' confidence and hope in their ability to cope in the mental health care environment</p>	<p>Clinical staff availed themselves to engage with students to solve their problems and assist them to cope in the mental health care environment</p>
	<p>Clinical staff shared their own experiences of mental health to reassure students and that they understood students' emotional experience</p>
	<p>Establishing a professional relationship with students was reassuring and helped to deal with fears</p>
	<p>Clinical staff recognised students' ability by allowing creativity which served as an affirming experience and thus boosted students' confidence</p>
	<p>Students were encouraged to report negative incidents in order to access clinical staff support</p>

	The value of mental health was imparted to students to give them hope and thus enable them to cope with the experience
<b>6C:</b> Empathic supportive interventions, behavioural coping and engagement with familiar educators was instituted by the clinical staff which created a sense of belonging and equality in students	Supportive interventions such as the buddy system and environmental change, supported students to cope in the mental health care environment
	Behavioural coping strategies such as crying was encouraged by clinical staff as it resulted in emotional catharsis
	Clinical staff recognised the need for students to engage with clinical supervisors that were familiar with them
	Clinical staff included students in activities to create a sense of belonging in students
	Clinical staff displayed empathy in supporting students
	Students were treated as equals thus they felt comfortable to express themselves, which assisted in coping with the emotional experience

**Theme 5C: Sharing their own experiences and availing themselves in a professional relationship, clinical staff engaged with and reassured students to allay fears and increase confidence in students' ability to cope in the mental health care environment**

Clinical staff reported sharing their personal mental health history and experience with students, to reassure them that they understood the students' emotional experience:

*"When they [students] ask me why did I want to do psychiatry...I ... got an interest...(when)... I realised my...uncle... who had ID [intellectual disability] ...*

*and...paranoid schizophrenic [schizophrenia]*

*"I would specifically focus and work on their fears. And share with ... how I've experienced it..."*

Through sharing personal aspects of their lives, the clinical staff may have sought to reassure the students that the emotional distress they experienced was not peculiar to them alone, as they too shared similar experiences. They availed themselves for student support by being accessible and providing information about the mental health care environment to students, as the data extracts illustrate:

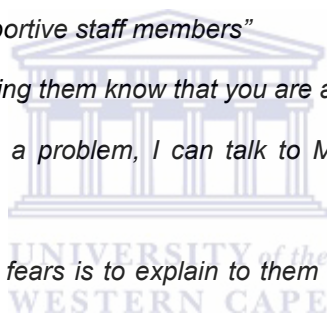
*"I tell them...we're available if they have difficulty coping. They can come and talk to us"*

*"... on the wards, there are very supportive staff members"*

*"...creating an open door policy... letting them know that you are available..."*

*"...they [students] know... if I have a problem, I can talk to Ms..... I can ask for guidance"*

*"One of the best ways to allay those fears is to explain to them what's it's all about and to reassure them"*



Additional support in the mental health care environment included clinical staff encouraging students to report negative incidents, so that they could be supported:

*"I...tell them about channels of communication like not for one to be hit...by the patient and keep quiet and go and report at the college[HEI], because we must deal with this at ground level [at the mental health care setting]"*

*"I just want them to be open and honest. If an incident did happen, they must report it...you can only support a person if you know what one is going through... we are really supporting them and we are willing to help"*

The participants felt that the support provided after negative incidents concerning students, had to be dealt with in the mental health care setting as it was a clinical responsibility. Supportive interventions included debriefing of students:

*"...if something specific happened then we try and debrief them immediately after that. Sometimes they just want to debrief in general"*

*"you can just support as like trying to debrief at the time of the onset. Otherwise nothing further"*

However, there appeared to be no further intervention following the initial debriefing of students in the clinical setting. This would imply that if students were still distressed thereafter, there was no other support for them from the clinical staff. This appeared to be correct, as the clinical staff felt that students preferred to convey their distress to educators that were familiar to them:

*"...they talk easier to the mentors [educators] than to us... they have come [on] quite a while with the mentors"*

Students have relatively short term clinical placements in mental health care settings as alluded to earlier, thus the clinical staff may not see themselves as having an active role to play in the emotional support of students as the focus of the placement may be on the attainment of the clinical learning objectives. Educators on the other hand supervise the students over a year-long period and may thus be perceived as providing stability, which in itself may be deemed supportive.

Despite the lack of support, the participants felt that students needed to be trusted to undertake activities in the wards, which would boost their confidence:

*"she trusts us enough to do it"*

*"I had complaints from some of these students where they felt that they weren't...allowed to do certain things. So if you don't boost their confidence, they're*

*going to feel like are we not good enough”*

If students have clinical confidence, the mental health experience may be appraised as being positive which may aid coping if faced with negative incidents. Positivity was further enhanced by a clinical staff member, who reported providing students with hope to grow through the experience:

*“... nothing is lost but everything is gained in Mental Health”*

**Theme 6C: Empathic supportive interventions, behavioural coping and engagement with educators created by clinical staff a sense of belonging and equality in students**

Clinical staff reported showing empathy when students were distressed following the death of a peer. Empathy is important as it suggests human understanding and the notion of ‘I care’, which may have been recognised by students as being supported during emotional distress:

*“Once there was a colleague of theirs that passed away. She had cancer. They were all very sad...I called them and... said...is there anything that you want me to do? I know you are all sad”*

*“...I would allow them...space to cry...then...ask them if they are okay. Is somebody coming to fetch you? Should I call somebody to fetch you?”*

Students have to contend with many emotional challenges in the mental health care settings. Distress resulting from the death of colleagues may further exacerbate the distress experienced by students in the mental health care setting.

In order to create a supportive mental health care environment for students, a participant reported encouraging students to buddy with experienced staff. This meant that students would no longer feel isolated in the mental health care

environment. They learn from staff members and gain confidence in their ability to care for mentally ill patients, as illustrated by the following quotation:

*"I would tell them the buddy system, to shadow one staff member... link onto a staff member and just follow the staff member"*

Other supportive interventions include environmental change for traumatised students. The participants recounted that they supported students who had been traumatised or had similar experiences as patients by transferring them to other wards. Clinical staff member reported:

*"...the student has been removed from that ward, because she can't work there anymore. You can't work where you have had a trauma"*

*"If it means that the ward is too much and is... reflecting on something that is happening to you [student], maybe just take you out of there for a little while and place you in a ward that will be much more comfortable..."*

Changing the working environment may be deemed supportive, as the students do not have to re-live the traumatic events which may increase students' emotional distress.

Clinical staff also reported that they encouraged students to cry following an incident; crying may be considered to be cathartic for some students:

*"Some guys... threatened them [students]. You [student] can cry if it...makes you feel better"*

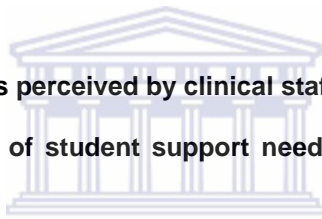
In addition to behavioural coping, clinical staff reported that they included students in activities held at the various facilities to create a sense of belonging. Students were also made to feel equal to the clinical staff, which the clinical staff deemed to be supportive:

“...so we invite them (the students). We want them to be part, we want them to belong”

“in everything that we’ve done...Nurses Day celebrations...goodwill teas...we’ve made our students part of that..”

“...they [students] feel comfortable with me because I treat them on an equal. They are free to ask or express”

However, as alluded to earlier, clinical staff stated that students did not trust them and thus did not disclose their feelings to them. It would then appear that the support clinical staff offered was dependant on an interpersonal relationship between themselves and the students.



#### 4.3.6 Support needs of students as perceived by clinical staff

**Table 4.9: Themes and categories of student support needs as perceived by clinical staff**

THEMES	CATEGORIES
<p><b>7C:</b> Their awareness of support services was limited, as most clinical staff were uncertain while others recognised a lack of support services due to limited structured support; as a result clinical staff mainly used informal support, including peer support, which impacted negatively on referral of students who needed intervention</p>	<p>Clinical staff were unaware of support services for students, which impacted negatively on referral of students</p>
	<p>Clinical staff recognised the lack of support for students, the differences between student and staff support, and the adverse effect it had on the students’ emotional experience</p>
	<p>Student access to emotional support in the clinical setting, followed a hierarchal system of reporting and intervention</p>
	<p>Orientation and introduction of students included safety precautions to orientate students to the mental health care setting</p>
	<p>Reporting of incidents followed the same</p>



	<p>procedure for both students and staff, although the support given differed</p>
	<p>Clinical supervisors were identified by clinical staff as support persons for students, in the mental health care setting</p>
	<p>Clinical staff felt that students relied on them for support concerning personal and professional issues, although they offered support in the absence of the clinical supervisors</p>
	<p>Students were perceived to be supportive towards each other, which was encouraged by clinical staff</p>
<p><b>HEI</b></p> <p><b>8C:</b> The need for a support centre, with a range of services which adopted multidisciplinary team approach. Specific telecommunication services and physical orientation to the settings were identified</p>	<p>Clinical staff identified a support centre with a person to help students privately</p>
	<p>A psychologist who is accessible and available for students to talk to</p>
	<p>Understanding experienced lecturers and empathetic mentors who were humane, were identified to support students</p>
	<p>A helpline manned by a counsellor who listened to student concerns anonymously, was identified to assist students</p>
<p><b>Clinical services support</b></p> <p><b>9C:</b> The need for structured student support by an independent support person who liaises with the HEI, and orientates and gives feedback to students to create a sense of belonging.</p>	<p>Clinical staff identified the appointment of an independent support person that they could talk to</p>
	<p>Student support needed to be formalised, as student support was provided by interested staff</p>
	<p>Clinical staff's support role included the need to protect, mentor, and debrief students</p>
	<p>Clinical staff felt that students should visit the institution prior to their clinical</p>

	placement, as this would allay fears
	The need for liaison between the clinical setting and the HEI was established, thus impacting positively on student support
	Orientation of students by registered nurses. Students were identified as important to create a sense of belonging in other students
	Clinical staff felt that feedback had to be given on time, as this was deemed supportive
	Staff and students should receive the same support in terms of support groups

**Theme 7C: Awareness of support services was limited, as most clinical staff were either uncertain or recognised the lack of support services - of which formal support was limited with clinical supervisors utilising informal support mainly, which impacted negatively on referral of students who needed intervention**

Clinical staff reported that they were either unaware or unsure of support services for students. A reason cited, was that clinical staff were not alumni of the University of the Western Cape. Another participant however assumed that there would be support for students, as institutions needed to support the students:

*"Maybe they've [HEI] got other undergrad [undergraduate] support system which I'm unaware of. I studied at the college and not at the university. So I'm unfamiliar with the services they [HEI] render or that is available to them [students]"*

*"I don't know...I'm sure that they do have support there... any college has got policies... as we've got...at the hospital"*

Clinical staff may not be conversant with specific supportive resources that are available to baccalaureate students, as students from colleges are also placed in the mental health clinical setting. However, student wellbeing is compromised when clinical staff does not know the student support referral systems for supportive interventions in the event of trauma or when there is a valid need for supportive interventions.

Although they did not know where to refer students to, clinical staff recognised the lack of support for students, the differences between student and staff support, and the adverse effect it had on the students' emotional experience.

*"...this part is really saddening when a client attacked a student but that is as far [mental health care environment] as we go... with them, it's like you're here...for your own training, but what about your hurting..."*

*"...most of the things for the students must be referred to the university...it means that students get different treatment compared to staff whereas we are all staff. ...if it is a student then you have to report... and do the first aid things, but this needs to be reported to the university... We don't know which university, which doctor and everything..."*

The participant displayed a sense of helplessness knowing that although they perceived students as staff, supportive interventions were not available to students. Clinical staff seemed to be of the opinion that all student incidents needed university referral. However, they were unaware about which training institution students came from. This may be because large numbers of students from various nursing education institutions, such as nursing colleges and universities are placed in the mental health care settings. There may not be a system in place to track all the students, hence the confusion about the students' origination. This may impact

negatively on the students' emotional experience in the mental health care setting because students may be perceived as a collective, which by implication infers an attitude of 'one size fits all' by clinical staff.

It is, however, evident that students were not referred for the necessary support because the support services were unknown. Students may have been expected to access their own support, which may not have transpired as students may have been too distressed to seek support.

Some participants, however, reported that there was a referral system following student incidents in the clinical setting, which consisted of a hierarchal system of reporting and intervention as illustrated by the following quotations:

*"If students are traumatised...the first contact person would ... be the registered nurses in the wards. They would ...assess...and reassure... we have...the student coordinator...if we feel that they need further intervention, we'd...inform Manesh [student coordinator]. He would... inform the...lecturers..."*

*"...the mentors [educators] with the ward sisters...are there and me as the contact person. We can make a referral. They can be referred to a psychologist or...to your university"*

It would appear that there were no formal student referral procedures in the mental health care settings, as facilities differed in terms of the support offered or lack thereof that they provided to traumatised students. Clinical staff reported that included safety precautions as a part of the support they offered when they conducted the orientation of students to the mental health care setting:

*"my orientation about Lentegeur [a psychiatric hospital] of what to experience..."*

*"I will also tell them never to turn their backs on psychiatric patients because they are unpredictable"*

*“They know exactly what kind of patients are there. What they might expect, but we try by all means to prevent that not from happening. That is why we’ve got securities with them. They don’t work alone ... there is always professional nurses, staff nurses and the unit manager...”*

It appears that students were informed about the types of patients and also warned about mentally ill patients’ negative behaviour. Negative behaviour management focused on ensuring that students never worked alone with patients, to safeguard them in the unpredictable mental health care environment.

If incidents did occur whilst students were working with patients, then the reporting of the incidents followed the standard incident reporting procedure applicable to all staff working at the facilities:

*“...procedurally we’ll follow the incident reporting whereby we record...and have it sent up to the CEO and the management to see”*

Reporting of incidents may be a paper exercise, where clinical staff do what is procedurally correct but offer no support to the student who has been traumatised. However support, according to the participants, was offered by the clinical supervisors [educators] as this was assumed to be their responsibility. Participants felt that the clinical supervisors were available and conversant with student issues:

*“As long as the mentors [educators] are available”*

*“...there’s supervisors... they...come frequently...they know what to do when the students are having or are going through...traumas...”*

*“...the student files ... I once read through it. It ... said that they ... need the support from the clinical supervisor”.*

The participant, an operational manager, made reference to a student file in the mental health care setting. The student file is usually compiled by the clinical staff in

the various mental health care settings, to give guidance relating to student matters like - for example absenteeism or needle prick injury to name but a few. It appears that the clinical staff felt that student support was the responsibility of the HEI, hence the reference to clinical supervisors giving support in the student file. Despite the perception that student support was an educator responsibility, the participants felt that the students were reliant on them for support concerning personal and professional issues, in the absence of the clinical supervisors:

*“They are relying on the staff on ground level (for support)”*

*“Supervisors are not around, which somehow does impact. We have to call them aside, talk to them and support them...”*

*“Now it is coming on personal one to one intervention coming up other than the schooling thing”*

The participant described how students sought individual consultation relating to personal issues during the clinical placement. This could be the result of the clinical staff's dedication and interest in the students' emotional wellbeing, as alluded to by a participant:

*“we get nurses who go all out to know their students – in and out. ...dedicated professional nurses and operational managers. They're willing to sit and listen to the student and they will try to assist...”*

Operational managers that are professional nurses who manage a few wards and professional nurses that were devoted to student needs were identified as being supportive. Operational managers in the clinical setting are usually professional nurses who have studied further courses or degrees. These individuals may have been identified, as they are perceived to being empathetic to students needs by

virtue of having gone through similar experiences in the course of their own studies.

Support included communicating and taking the necessary action if needed.

Students on the other hand were perceived as being supportive towards each other, which was encouraged by clinical staff. Participants perceived peer support as creating a sense of security and belonging in the students, as illustrated by the following quotations:

*"...this student [these students] rely on each other to understand..."*

*"Two of them [students] are going to the pharmacy...you understand... because of that emotional support. It is as if when they go outside, maybe they will ...meet these clients...it's a sense of security and a sense of belonging...they always want to be clicking [with] each other"*

*"...they [students] do support one another.... Sometimes... you can hear from the other one actually that this has happened"*

The participant alludes to peers reporting their colleagues' issues, which are indicative of peer sharing. Students may engage in peer-sharing, as fellow students are perceived to have experienced similar clinical issues.

#### **4.3.6.1 Support needs of students as perceived by clinical staff relating to the- HEI**

**Theme 8C: The need for a support centre, with a range of services which adopted multidisciplinary team approach. Specific telecommunication services and physical orientation to the settings were identified.**

Clinical staff reported that a support centre for nursing students at the School of Nursing at the University of the Western Cape should be established. A non-educator which may be a psychologist should be appointed to render the support. The person however must be available and accessible to students when the support is needed:

*“...support centre at the department for them...”*

*“... a counselling centre for them”*

*“...a person appointed, specifically... you know it is confidential. It is not going to be all around the whole school”*

*“...if it is a psychologist that is... there for them just to know that it's open, we can come talk anytime”*

However, the clinical staff felt that educators also had a role to play in supporting students at the mental health care settings. This was largely because educators were recognised as having both clinical and academic experience, thus they would have the necessary knowledge, skills and attitude to deal with student issues. Values which educators (identified by participants as mentors) should possess in dealing with students included empathy and humaneness:

*“you got... clinical... and academic experience...so you can identify if a student would come to you and say, I've got a problem... you can understand where he or she is coming from at a hospital setting. You have the knowledge of an academic setting of the stresses they [are] relating”*

*“Be more empathetic...the mentors should be more humane”*

Participants also identified the need for students to experience a site visit to the mental health care setting prior to their placement. This may be to allay fears the student might have:

*“let them have a walkabout before coming to the actual placements”*

Supportive interventions identified by the clinical staff included the availability of telecommunication strategies, which would enable students to seek support anonymously:



*“...if there can be a line that is open...some... times, people just want someone to listen...”*

*“...need to phone in and have a counsellor there at any given time...”*

*“...if there’s a helpline to...address their concern anonymously...”*

It appears that participants felt that the existence of a life-line concept would create relief for emotionally distressed students who may want to access support anonymously.

#### **4.3.6.2 Support needs of students as perceived by clinical staff relating to the mental health care setting**

**Theme 9C: The need for structured student support by an independent support person who liaises with the HEI, and orientates and gives feedback to students to create a sense of belonging.**

Participants felt that student support needed to be formalised in the mental health care settings. The support should be in the form of a programme as participants reported:

*“We do need support structures...for our students...but having a support structure...in black and white...”*

*“... a structured, formal thing to say, this is your programme...this is where you get help”*

The formal support structure would include the employment of an individual who was not a clinical staff member, as students may question the person’s loyalty towards them. The tasks of the person identified would include the placement of students to the wards and being in close contact with the educators supervising the students in

the mental health care setting. The focus of the contact would be on students' emotional wellbeing:

*"...it is better...to have an outside person...because they're scared it could be discussed with the other people"*

*"...tasked with students placements and... through close liaison with... the supervisors...to inform the school to say that we're doing okay..."*

Clinical staff saw themselves as also having a role in student support. The role included offering orientation, protection, nurturance and mentoring of students. Protection may be deemed important given the unpredictability of the mental health care environment. Students are inexperienced and therefore need to be protected, nurtured and mentored by experienced nursing staff to develop into emotionally confident individuals:

*"... when students are placed in a setting and... they are properly orientated... if the expectations are clearly stated... their roles are very clearly defined as students but also...as a team member...they...have a greater sense of belonging...that needs to come from the professional nurses who...mentors... supervises...and guides them"*

*"while they're here with me I should be...their protector, their mother figure..."*

*"we have ....(to) protect them emotionally"*

*"...to be mentors... willing to fulfil a mentoring role..."*

Clinical staff alluded to the need to intervene when students were emotionally traumatised; they felt that students needed debriefing which should be formalised. Debriefing as an intervention may be utilised to help students to cope with the traumatic experience:

*"...it's...important that when a student is...traumatised by an assault...they need debriefing immediately"*

*“If it can be a formal debriefing session”*

The need to establish a liaison between the clinical staff and educators was identified by the participants. One way to promote the liaison was for educators to attend clinical staff meetings at the facilities. Attendance of meeting by educators may be informative, as student issues are also raised in the meetings. Clinical staff and educators would have the opportunity to clarify students' issues and plan joint supportive interventions for students:

*“We [clinical staff and educators] need to work very closely”*

*“...keep that networking going... that channel of communication open...”*

*“these people who are doing the accompaniment... join us... when we have our meetings...”*

In addition to working closely, participants felt that student issues need to be addressed as feedback should be given timeously. Addressing students issues and reporting back on the process, signifies to the recipient that time and energy were expended on the matter and thus the student may feel worthy:

*“...the feedback must reach them timeously...”*

A participant reported that mental health support services in the facilities should be accessible to staff and students. These services included staff support groups, as a clinical staff member reported:

*“...there should be...staff support groups...so anything that goes for the nursing staff would be the same that would go for the students”*

Support groups would offer students the opportunity to vent their feelings and access support from the more experienced clinical staff. Emotional challenges between staff and students may be addressed and resolved, which may contribute to a positive mental health experience for students working in the mental health care settings.

#### **4.4 SECTION 3: DISCUSSION OF FINDINGS**

The following section is a discussion of the findings across all participant groups, according to Lazarus's Transactional model of stress and coping which was used to structure the findings, namely: emotional responses, student coping, emotional support needs. In presenting the discussion, the themes were carefully cross-referenced against each other, to identify possible horizontal themes which would serve as concluding statements.

##### **4.4.1 Emotional responses of students**

*The purpose of this section is to capture the experiences of students working in mental health care settings in the Western Cape.*

As indicated in chapter one, the mental health care environment has been described by various authors as a very stressful environment for nursing students. The purpose was therefore to explore and describe the experiences in terms of the emotional response of students to the stressful mental health care environment. Educators and clinical staff were also asked to describe their perception of the students' experience of the mental health care environment. The rationale behind this line of questioning was the researcher's belief that only when educators and clinical staff can identify and acknowledge students' emotional responses and how they coped will they be able to identify what can be done to emotionally assist students, i.e. identify emotional support needs, which is the aim of this study. A summary of the themes and categories for all three participant groups is depicted in table 4.10.

**Table 4.10. Summary of vertical themes relating to emotional responses of students per participant group and resultant concluding statements**

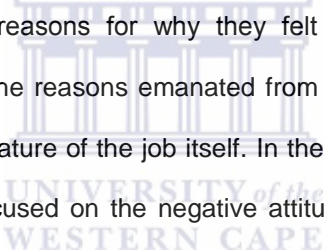
STUDENT NURSES	EDUCATORS	CLINICAL STAFF	CONCLUDING STATEMENTS BASED ON HORIZONTAL THEMES
<b>VERTICAL THEMES AND RELATED CATEGORIES</b>			
<p><b>ORGANISATIONAL</b></p> <p><b>THEME 1A: Negative staff attitudes influenced by the transitory nature of students' placement increased the students feeling of being unprepared, undermined, prejudiced and alienated - however incongruence resulted when the students witnessed the staff rendering mediocre nursing care</b></p> <ul style="list-style-type: none"> <li>- Staff's lack of acknowledgement of the senior students, the impact of the transitory nature of the students' placement and students' unpreparedness to work in mental health care settings conjured up the feeling of alienation.</li> <li>- The emotional experience resulted in the students undermining their ability to be of assistance to the patients.</li> <li>- The attitude of staff and prejudice against them being UWC students impacted negatively on the students' emotional experience</li> <li>- Mediocrity of the nursing care witnessed resulted in students experiencing negative emotions.</li> </ul> <p><b>THEME 2A: Stigma by association, violence and the physical appearance of patients were related to feelings of traumatised and fear in students</b></p> <ul style="list-style-type: none"> <li>- Student's fears were related to possible stigma by association, the reality of staff as patients, the patients themselves, the clinical environment and the stories that they heard.</li> <li>- Acts of violence involving patients, staff and students resulted in feelings of fear and traumatised.</li> <li>- Traumatization as a result of the patients' behaviour</li> </ul>	<p><b>ORGANISATIONAL</b></p> <p><b>THEME 1B: Availability of ward staff and clinical supervisors to support students were contradicted by reports of negative staff attitude and lack of support for students. Poor communication, lack of support from the HEI as well as students' lack of preparation, distrust of clinical staff and educators impacted negatively on their emotional experience.</b></p> <ul style="list-style-type: none"> <li>- Poor student behaviour resulted in clinical staff being negative towards students and not taking responsibility to supervise students despite students being regarded as workforce, resulting in an adverse emotional experience for students.</li> <li>- Support of the occupational and ward staff being available to support students.</li> <li>- Frustration at the lack of support for students from the HEI</li> <li>- Lack of communication between educators impacted negatively on the support given to students.</li> <li>- Il-preparation for intellectually disabled patients due to non-exposure based on upbringing.</li> <li>- Lack of trust in clinical staff by students resulted in non-verbalization of students issues</li> <li>- Distrust of educators based on unfamiliarity with them</li> </ul>	<p><b>ORGANISATIONAL</b></p> <p><b>THEME 1C: Positive staff attitudes and role modelling were limited. However to a large extent the workload, clinical environment and negative attitudes of staff and lack of role modelling impacted negatively on the students' emotional experience</b></p> <ul style="list-style-type: none"> <li>- Work overload has a negative effect as students are unable to meet their own learning needs</li> <li>- Negative staff attitudes had an impact on the emotional experience of students</li> <li>- The staff's positive attitude had an affirming effect on the students' emotional experience</li> <li>- The type of ward that students were placed in and the lack of role models had an emotional effect on students</li> </ul>	<p>Students experienced the lack of a sense of belonging which was influenced by staff attitude, perceived unpreparedness of students, lack of role modelling and the stigmatisation and nature of the work environment which induced fear, anxiety and traumatised. Distrust resulted in lack of communication which could have resolved the perceived lack of support</p>

and physical appearance.			
<p><b>SOCIOLOGICAL</b></p> <p><b>THEME: 3A Socio-cultural beliefs about mental health care users evoked feelings of confusion for some students while others experienced it positively as they were able to assist their families with the knowledge gained.</b></p> <ul style="list-style-type: none"> <li>-Strong cultural influences on the belief in myths about, and stigmatization of mental health users rendered students confused as they learnt about mental illness.</li> <li>-Students confidence to assist the family increased</li> </ul>		<p><b>SOCIOLOGICAL</b></p> <p><b>-THEME: 2C Students' socio-cultural background, family responsibilities and expectations of the family regarding the students' role as a nurse within the family had an impact on their emotional experience</b></p> <ul style="list-style-type: none"> <li>-The students' response and understanding of mental health was influenced by their background which impacted on their emotional experience</li> <li>-The students' family responsibilities and expectations of the family on the student as a nurse had an impact on their emotional experience</li> </ul>	<p>The strong influence of the sociocultural background of students, family responsibility and expectations influenced their experience. This experience was positive when knowledge gained could resolve preconceptions about mental health</p>
<p><b>PSYCHOLOGICAL</b></p> <p><b>THEME:4A Negative affective states, altered cognition and carer stress impacted adversely on the students' will to seek support, physiological or psychological, and their attitude towards mental illness, However some students' experience was positive as they developed self-awareness which resulted in self-diagnosis and self-management</b></p> <ul style="list-style-type: none"> <li>-Self-reflection and questioning the existence of mental illness created inner turmoil</li> <li>-Undermined own ability to be of help to the patients.</li> <li>-Became judgmental and non- therapeutic when reports of the patients' behaviour were negative.</li> <li>-Emotional attachment and the inability to detach despite the personal perception of professionalism resulted in students feeling consistently burdened</li> <li>-Alterations in sleep patterns, gastrointestinal, respiratory and cardiovascular effects</li> <li>-Crying and irritability occurred</li> <li>-Students self- and other diagnoses based on real or perceived signs and symptoms of mental illness created fear and shame which negatively affected their support seeking behaviour</li> <li>-Experience and knowledge about mental illness resulted in self-awareness which led to self-management.</li> <li>-Alterations in cognition and sleep patterns occurred.</li> </ul>	<p><b>PSYCHOLOGICAL</b></p> <p><b>THEME: 2B Students' experience of the mental health care environment resulted in adverse emotional symptoms. An increase in the students' knowledge of psychiatry led to self-diagnoses and presentation of clinical symptoms of psychiatric illness as they identified with the patients' histories.</b></p> <ul style="list-style-type: none"> <li>-Students experienced the mental health environment as draining, frightening, shocking, and anxiety-provoking due to the nature of the work and the patients' condition</li> <li>-Identifying with patients' histories evoked personal issues in the students resulting in emotional distress</li> <li>-When students gained knowledge of psychiatric nursing, they diagnosed themselves or presented with clinical diagnosis</li> </ul>	<p><b>PSYCHOLOGICAL</b></p> <p><b>THEME: 3C Processing of the mental health experience heightened the students' self-awareness, uncovering their own unresolved issues which were projected either positively or as non-verbalization, emotionally draining, traumatic and alarming.</b></p> <ul style="list-style-type: none"> <li>-Working in a mental health care environment increased the students' self-awareness</li> <li>-Lack of trust and confidence in clinical staff resulted in non-verbalization of experiences</li> <li>-Students identified with the patients' histories, diagnosis which uncovered their own unresolved issues</li> <li>-Working in the mental health care environment was emotionally draining and traumatic</li> </ul> <p><b>THEME: 4C: Fear and anxiety related to the negative stories and stigma about psychiatric patients, negative patient behaviours and students' lack of knowledge to manage these behaviours</b></p> <ul style="list-style-type: none"> <li>-Working with intellectually disabled patients was distressing for the students.</li> <li>-Stigma and negative stories about psychiatric patients conjured up feelings of fear and uncertainty</li> <li>-Students displayed fear related to the patients'</li> </ul>	<p>Students' age, affective state and knowledge about mental health influenced self-awareness and self-diagnosis leading to self-management and the resultant psychological responses.</p>

<ul style="list-style-type: none"> <li>-Negative experience resulted in a display of negative attitude towards mental health</li> <li>-Positive attitude of patients and staff resulted in a positive experience for students</li> <li>-The source of students' experience of signs and symptoms of burnout were multifactorial</li> </ul> <p><b>THEME 5A: Age was perceived to influence students' emotional experience. Student identification with patients' histories evoked suppressed feelings</b></p> <ul style="list-style-type: none"> <li>-Students perceived feeling intimidated due to their young age.</li> <li>-Identified with patient histories' which evoked their own suppressed feelings</li> </ul>		<p>physical and verbal aggression and intimidation</p> <p>Experienced anxiety due to their lack of knowledge and readiness to manage the patient symptoms</p>	
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Participants shared the view that students' mental health experience was predominantly negative and unsupportive. Students alluded mostly to their interaction with clinical staff. This may be because students spend most (24 hours per week) of the time in the clinical setting, under the guidance and supervision of the clinical staff. The educators, who supervise students in the various mental health care settings, accompany students in more than one psychiatric hospital and community mental health clinic. This would mean that the student placed at a mental health care setting will see the educator once a week for a period of one hour. It is therefore not surprising that the students and clinical staff interacted more frequently with each other than the educators.



The participants provided different reasons for why they felt that the students' experiences were mostly negative. The reasons emanated from the context i.e. the mental health care settings and the nature of the job itself. In the mental health care setting interpersonal relationships focused on the negative attitudes of clinical staff towards students and poor student behaviour. The nature of the job alluded to the heavy workload, lack of clinical preparation of students, the type of wards the students worked in. Negative patient behaviours such as violence experienced or witnessed also contributed to the students' negative experience.

The negative staff attitudes experienced by students appeared to emanate from the fact that students were from a university. They were perceived to be theory-orientated and thus having no clinical skills. While Bunce (2002) refers to university students having unrealistic expectations of their clinical placements and what nurses do, in this study the students were prejudiced for their affiliation to the University of the Western Cape. The prejudice students experienced by the clinical staff towards



UWC students may also have contributed to feelings of inadequacy and insignificance. Prejudice refers to a preconceived opinion that is not based on actual experience ([www.merriamwebster.com](http://www.merriamwebster.com)). It appears that students endured significant emotional distress in the mental health care environment. This is concerning, as the staff complement in the mental health care settings is also made up of the University of the Western Cape alumni.

Students appeared to lack confidence in their skills and could not articulate them with conviction, which resulted in distress. This was especially true when they were dissuaded from implementing what they had learnt. This finding is supported by Wells et al (2000) who conducted a study in Ireland on exploring the factors inhibiting the recruitment of psychiatric nurses. These authors found that psychiatric students lacked clinical confidence as they perceived themselves to be inferior in terms of their skills base.

Educators however, felt that students displayed poor behaviour in the clinical settings, hence the reason for the clinical staff's negative attitude towards them. These behaviours may include students sleeping on duty, absenteeism and disinterest in learning. However, both educators and clinical staff alluded to students being part of the workforce in the mental health care setting, though educators perceived clinical staff not to be involved in student education and training. This received confirmation from both educators and students, who reported the distress students experienced when they were ignored by clinical staff or told to sit outside with the patients. The distress may stem from the need to belong. Belonging is defined as students having an affinity for nurses and nursing ([www.Oxforddictionaries.com](http://www.Oxforddictionaries.com)). Beyer and Nino (2001) avows that belonging encourages identification with a group (nurses) which according to De Dreu, West, Fischer and

MacCurtain (2001) shapes human behaviour. Behaviours, according to De Dreu et al (2001), which constitute belonging include frequent interaction, continuity and stability, mutual concern and being free of negative affect. Thus when a student feels that he or she belongs to the group (mental health nurses), they portrays behaviour such as commitment. Students need to feel a sense of belonging in order to be committed to the nursing profession. When there are real, potential or imagined changes in belonging, then emotional reactions are evoked which lead to students feeling that they are deprived.

The important issues for nursing, however, arises about the image of mental health nursing, the lack of role modelling for the future mental health nurses and the recruitment and retention of mental health nurses. Mental health nursing may be perceived to be uncaring or jaded based on the abovementioned information. Cleary and Happell (2005) assert that it is important that students have a positive mental health clinical experience, if the recruitment crisis in mental health nursing is to be addressed. Feelings of distress could also damage or impair health (Stranks, 2005).

The workload in the mental health care environment increased the students' distress. All participant groups reported that the students were part of the workforce. Given the shortage of nurses in mental health hospitals, the utilisation of students as a part of the workforce was expected. However, students found this distressing as they were unable to meet the learning objectives of the nursing programme. It appeared that the priority of the clinical environment was patient care. Students were reassigned to wards during the placement period when clinical staff did not report for duty. These changes were made irrespective of whether the student had attained the clinical learning objectives. Students also worked unsupervised by professional nurses.

Given that students were already burdened by the multiple roles (breadwinner, spouse, parents, student) they had to assume in their lives, having the additional burden of being part of the workforce without the benefits (financial, support to name but a few) may have been very distressing.

All participants reported about the lack of student preparation to work in wards where acutely psychotic patients and intellectually disabled patients were admitted. Students were acutely distressed by working in these wards. The students' distress may have emanated from the reality that there are so many psychotic or intellectually disabled patients. Students' exposure to psychotic patients may be limited, as psychotic patients are usually cared for in mental health institutions. If they are admitted to general hospitals, they are usually placed in secure rooms away from the physically ill patients. They may have been exposed to intellectually disabled patients in the communities where they live but given the stigma and ignorance about mental disability, a plausible explanation may have been given for the person's diagnosis. It appears that students' distress was further exacerbated when the intellectually disabled patients were physically disabled as well. Clinical staff however, appeared to comprehend the students' distress about working with intellectually disabled patients. The students' articulation of their distress may have presented with observable behaviour such as crying, which signified distress and hence the support from the clinical staff.

Students and clinical staff reported on the experience of violence and aggressive behaviour in the mental health care settings. Violence in the mental health care environment is not uncommon, given the types of patients (for example psychotic) and the circumstances under which the patients are admitted to the mental health

institutions. Some patients are admitted involuntary according to the Mental Health Care Act 17 of 2002. This means that the patient may be a danger to himself or others and therefore refused admission to hospital. The patient will then be admitted involuntarily, this essentially means that his rights are removed and he is forcefully admitted against his will.

Students may experience the violence as affirming the stories they heard about mentally ill patients and violence. This is further affirmed by clinical staff who when they are conducting orientation, discuss safety precautions during the clinical placement. Students may become aware of the patients' propensity for violence during these discussions. In this study, both students and clinical staff reported on students being physically assaulted by patients. It is not surprising that students may have appraised the interaction with patients as threatening. Student safety in mental health care settings is priority for the HEI and mental health institutions, as students need to feel safe in the work environment. Fisher (2002) conducted a study in Australia which focused on critical incidents regarding second-year student nurses during their clinical placement. The results illustrated that 52% (n=148) of the students reported witnessing psychotic behaviour and incidents involving actual and threatened violence and verbal abuse by patients.

However, students also reported witnessing clinical staff physically assaulting patients, which perpetuated the notion that the mental health care environment is violent. The experience was emotionally distressing for the students. This finding is concerning and serious as it raises many issues around student education and training, professionalism in nursing and the duty to care. Students are placed in the mental health clinical environment to acquire knowledge about mental health, skills

and attitude which are obtained mostly from the clinical staff. They need professional nurse role models, so that they can emulate their behaviour and skills. It is no surprise given the students' experience, that a clinical staff member reported about the lack of or limited role models in nursing. Students mentioned the sense of powerlessness they felt at being unable to assist patients as they felt devalued, a student alluded to this with the following statement - "*we try to help but we not important enough*". The interpretation thereof may be that students' lacked confidence in their ability to assist patients.

Students' distress was further compounded by witnessing the mediocre nursing care that patients received, and helplessly stood watching how the patients were treated. What the students described as mediocre nursing care may in fact have been clinical staff setting boundaries with patients, and the students interpreted these actions of the nurses towards the patients as uncaring. Patients in mental health facilities normally require limited general nursing care, as nursing care is focused on therapeutic relationships. Students may have difficulty in comprehending the process of therapeutic relationships and perceive the care rendered as mediocre. Whatever the interpretation, the students were distressed by the experience.

Students' distress may not have been communicated to all the relevant role players, as there appeared to be a general lack of communication between all participants. Clinical supervisors (educators) felt that lecturers (educators) failed to give them feedback about the students that they had referred to them. Feedback is described as an interactive process whereby evaluative or corrective information about the student is transmitted to the clinical supervisor, to gain insight into the student's emotional wellbeing ([www. merriamwebster.com](http://www.merriamwebster.com)). As feedback was not given, the

clinical supervisors may have been unaware of their role in further intervention and emotional support of the student in the clinical setting. This could mean that there was a poor relationship between the educators. Lecturers may have regarded it unnecessary to inform the supervisors, as they may have already dealt with the students' issues. The clinical supervisors may have been unable to provide the emotional support to students, which may have been understood by students as being unsupportive. Student support may be compromised if clinical supervisors and staff are unaware of their support needs.

Students were uncertain of the implicit expectations from them, which created uncertainty and distress as they attempted to make sense of the emotional experience. This finding is supported by Van Rhyn and Gontsana (2004) who conducted a study in South Africa on student nurses' experiences during clinical placement in psychiatric hospitals. These authors found that professional nurses were detached from their teaching role, which is aimed at guiding students to assume responsibility for their nursing actions. This may be because clinical staff's primary focus was on rendering patient care and therefore students were expected to obtain supervision and guidance from the educators who, according to clinical staff, were not always present. Some clinical staff supported students, but it did not occur very often. Only clinical staff who were deemed to be "*student orientated*" or "*had a thing for students*", meaning to have a desire to teach, guided and supported students, and were thus reported by clinical staff to be supportive of students.

Students may have been perceived to be an additional load on an already under-resourced service. This then raises the question: how is nursing knowledge, skills and attitude expected to be transmitted to students to ensure the continuity of patient

care, if students are not supported by experienced nurses? It is then not surprising that both educators and clinical staff made reference to the students' lack of trust in them. Students preferred not to verbalise their distress, which is understandable given that much of the students' distress appeared to have emanated from the very people who were expected to provide support in the education and training of the student nurses.

Educators and clinical staff felt that clinical staff were supportive and displayed a positive attitude towards the students. However, based on the above discussion, this perception was negated by students. While some students referred to a positive mental health experience, most students' experience was negative. As experiences are subjective, the students may have had unrealistic expectations of clinical staff prior to placement in the mental health care setting. Clinical staff on the other hand, may have an inflated self-esteem which makes no room for criticism. Students' non-verbalisation of their negative experiences may reinforce clinical staff's perception that they are rendering support to students.

Given the dominance of the findings relating to the negative experience and negative attitude experienced by students, it is not surprising to note the distressing emotions displayed by the students.

However, students reported that they lacked knowledge and readiness to care for mentally ill patients. It is evident that they lacked confidence in their ability to care for patients and in some cases became emotionally attached to patients. Warelow and Edward (2007) cite Morse et al (1990) who contend that mental health nurses may become overinvolved with the patients, when their commitment is to the patient as a client rather than the patients' treatment goals. Assuming that this statement may be

true for professional nurses, the lack of clinical expertise of student nurses may make them even more vulnerable to this level of attachment. Therefore it is no wonder that the students were unable to detach from patients' experiences, which resulted in them feeling burdened by what they experienced in the clinical setting. Menzies (1988) in her seminal works on social systems as a defence against anxiety alludes to the psychological task of the development of professional detachment, in which a student must learn to control their feelings and refrain from excessive detachment in their work. This detachment may be implicit in the short term clinical placement of students at the various psychiatric hospitals. The expectation may be that students will learn professional detachment by frequent placement moves, which may be substantiated by gaining experience in various wards. It appears that the education and training of student nurses with the focus on comprehensive nurse training in South Africa, perpetuates psychological detachment which may be distressing for students.

Feelings of fear and anxiety also emerged, especially when students felt threatened. They felt threatened by the mental health care environment, the interaction with the patients, the type of patients and the attitude of the staff toward them. This finding concurs with Fisher (2002) who concluded from a study where clinical critical incidents taken from a cohort of second-year students undertaking mental health practicum, were analysed and 19.7% (n=70) of the students reported intense feelings of fear as the most common feeling arising as a result of the emotional experience. Fear in Fisher's (2002) study may have been related to the critical incidents such as witnessing psychotic behaviour involving both actual and threatened violence and verbal abuse by patients, as these dominated the critical incidents described. In this study, fear and anxiety were part of the myriad of negative emotions that students described in response to their emotional experience. Fear is described as a negative



unpleasant emotion caused by anticipation or awareness of danger, while anxiety is an overwhelming sense of apprehension and fear (www.merriamwebster.com.) Anxiety according to Lazarus (1999) is at its strongest when the individual has a poor perception of his ability to cope with the environment. Although these emotions may occur within student participants in the mental health context, the resultant distress needed to be contained in a safe supportive environment - which did not appear to occur with students in this study.

Clinical staff and students referred to the students' beliefs about mental illness which appeared to come from sociocultural beliefs. As the student body at the University of the Western Cape is diverse and South Africa has a rich multicultural history, this result was expected. However, as the data was collected at the end of the student placement and the nursing programme, the expectation was that students would have learnt to manage transcultural diversity. Students instead reflected on the perception that their upbringing was baseless, assuming that they recognised that rational explanations for mental illness existed. This caused much distress as students felt rootless, as their existence was perceived to be based on myths.

*"Well, emotionally, it made me feel I don't know where I'm coming from because of the way we do things. The way we judge people because it is not based on any... facts...it is just myths."*

It would appear that students felt that they were judging patients based on their own beliefs, which given their mental health experience appeared to have no credence. It is concerning that the student participants in this study appeared to be unable to integrate their own psychosocial cultural being, within their experience in the mental health care setting. The all or nothing approach appeared to prevail as students

appeared overwhelmed by their experiences, thus negating their cultural belief system to adopt a biomedical approach to mental health with devastating emotional consequences.

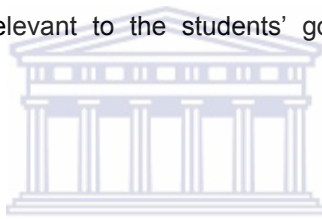
A number of students, however, developed in the mental health experience, which gave them confidence in their ability to be of assistance to others. All participants mentioned that the positive attitude of staff resulted in a positive mental health experience. This may be because students themselves were positive prior to the experience. Students may have been curious about the placements and thus entered the mental health care setting seeking possible answers for their questions about mental health and illness. Staff may have perceived this behaviour as engaging, as the students were interested in their surroundings.

All groups of participants reported on how students identified with patients' histories. This finding is not surprising, as individuals may experience similar circumstances during their lives. Students described the distressing emotions they experienced when they perceived themselves to have signs and symptoms of mental illness; the educators and clinical staff reported on the distress students experienced, when their personal issues were evoked when students identified with patients' histories. Ewashen and Lane (2007) assert that students may be unprepared for the complexities of psychiatric mental health nursing practice, especially when personal painful memories of their own life-events were vicariously evoked. These authors suggest that students may seek support from clinical staff and educators however pedagogic boundaries blur in the face of student distress.

Students further described the distressing emotions they experienced, when they perceived themselves to have signs and symptoms of mental illness. Freeburn & Sinclair (2009) conducted a study which aimed to describe the personal stress experienced by mental health students working in mental health care settings. Students participating in the study reported that they feared disclosing their stressors because of the risk of being labelled with a mental illness.

### **Summary**

The emotional responses of participants, particularly the students related to the self in transaction with the environment (objective and subjective world). Appraisal of the environment was deemed mostly relevant to the students' goal (completing the degree).



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#### **4.4.2 Student coping**

*The purpose of this section is to explore and describe how students coped in the mental health care environment and how educators and clinical staff assisted them with the coping process.*

A summary of the themes and categories for all three participant groups is depicted in table 4.12.

**Table 4.11: Summary of vertical themes relating to student coping per participant group and concluding statements**

**Comment [a1]:** Cut across what?

STUDENT NURSES	EDUCATORS	CLINICAL STAFF	CONCLUDING STATEMENTS BASED ON HORIZONTAL THEMES
VERTICAL THEMES AND RELATED CATEGORIES			
THEMES; CATEGORIES	THEMES; CATEGORIES	THEMES; CATEGORIES	
<p><b>ADAPTIVE</b></p> <p><b>THEME: 6A Utilization of social support, intrinsic resources, self-care activities and knowledge to cope when the environment was appraised by the students as being unsupportive</b></p> <ul style="list-style-type: none"> <li>- Students' access to family, peer and staff support enabled coping</li> <li>- Dealt with their own issues in the absence of support</li> <li>- Accessed intrinsic resources to cope</li> <li>- Inner strength gained through prayer instilled hope, perseverance and motivation in an environment which students perceived to be unchanging</li> <li>- Consciously diverted attention to deal with unpleasant thoughts</li> <li>- Engaged in self-care activities to cope</li> <li>- Knowledge of patient management increased students' confidence to deal with aggressive patients.</li> </ul> <p><b>MALADAPTIVE</b></p> <p><b>THEME: 7A The utilization of defensive coping and negative behavioural strategies, which were acknowledged to have short-lived effects.</b></p> <ul style="list-style-type: none"> <li>- Students ignored staff, blocked and disengaged from unpleasant experiences to cope with the mental health care environment</li> <li>- Students engaged in shopping, substance abuse and clock-watching to cope with the negative experiences in the mental health care setting</li> </ul>	<p><b>THEME: 3B Availability of educators for individual student consultation and role modelling of constructive communication skills to ascertain student coping and to assist them to cope in the mental health care setting</b></p> <ul style="list-style-type: none"> <li>- Available to students for one-on-one consultations which students preferred, and sharing of the educators' own experiences to show that they understand</li> <li>- Educators listened to the students, they enquired whether students were coping and motivated them, and they used empathy in trying to assist students to cope with the experience</li> <li>- Inquired about wellbeing to ensure that students felt supported.</li> <li>- Referred students to the student support services</li> <li>- Liaison between colleagues to raise awareness of students in need</li> <li>- Creating a peer support system and allowing self-exploration allowed students to rely on each other strengths and increase their confidence</li> <li>- Encouraged students to use discretion when identifying role models</li> </ul>	<p><b>THEME: 5C Sharing own experiences and availing themselves in a professional relationship, clinical staff engaged with and reassured students to allay fears and increase confidence and hope in students' ability to cope in the mental health care environment</b></p> <ul style="list-style-type: none"> <li>- Clinical staff availed themselves to engage with students</li> <li>- Shared their own experiences of mental health to reassure students</li> <li>- Establishing a professional relationship with students was reassuring to deal with fears</li> <li>- Recognised students' ability by allowing creativity which served as an affirming experience thus boosting student confidence</li> <li>- Students were encouraged to report negative incidents to access clinical staff support</li> <li>- The value of mental health was imparted to students to give hope.</li> </ul> <p><b>-</b></p> <p><b>THEME: 6C Empathic supportive interventions, behavioural coping and engagement with familiar educators created a sense of belonging and equality in students</b></p> <ul style="list-style-type: none"> <li>- Supportive interventions such as the buddy system and environmental change supported students' coping</li> <li>- Clinical staff recognised the need for students to engage with clinical supervisors which were familiar with them</li> <li>- Clinical staff displayed empathy in supporting students</li> <li>- Students were treated as equal thus they felt comfortable to express themselves</li> </ul>	<p>Students utilised social support, emotional self-care activities and knowledge to cope, when defensive and negative behavioural strategies did not improve their ability to cope; whilst educators and clinical staff availed themselves for student consultation and role modelled constructive communication to allay students' fears and to increase self-confidence.</p>

Communication within an interpersonal relationship emerged as a major concept in student coping. Communication is defined as process whereby meanings are exchanged between two or more individuals (Netshikweta & van Vuuren, 2012). In this study, communication is the process whereby participants (students, educator and clinical staff) engage in a process of exchanging meaning about the mental health care environment. These meanings were directed by educators and clinical staff at assisting students to cope with the mental health care environment. Communication consisted of making themselves available for individual student consultation, engaging with students by sharing own experience of the mental health care environment and employing some communication skills such as listening. Students may prefer to seek support individually as they may not feel comfortable articulating their distress in front of their peers or others. Hall (2003) asserts that students need a “safe space” where they can engage with educators in a reciprocal dialogue away from the classroom environment. The safe place may mean a place where the student feels welcomed, understood and cared for rather than a physical space.

Through being available, educators and clinical staff signify to students that their emotional wellbeing is important. Availability is described as being at someone’s disposal ([www.oxforddictionary.com](http://www.oxforddictionary.com)), which meant that students experienced the availability of the educators and clinical staff to signify that they were not alone. By sharing one’s experience in the face of student distress, may have reassured the students that they were not alone. Educators and clinical staff may have experienced similar events and coped, therefore this may give hope to the student that overcoming the distress is possible. This gesture may have been construed as being supportive by the students.

The participants (educators and clinical staff) reported that they engaged in a range of communication skills, to support students in the mental health care environment. These included listening, empathy, motivation and finally referral when students needed professional intervention. Listening is the ability of the educators and clinical staff to capture and understand the messages that students convey to share their experiences of the mental health care environment (Egan, 2013).

Educators reported liaising with their colleagues to ensure that distressed students were identified and attended to promptly. Liaising is important between colleagues, as there may be pertinent issues that students are facing and given the large amount of students placed in the mental health care environment, these issues may not be addressed by clinical staff and educators. Addressing students issues quickly may prevent exacerbation of emotional issues, which can have devastating consequences such as students resorting to maladaptive coping strategies to cope with the experience.

Students seeking support from peers was encouraged by both educators and clinical staff, as students may be seen to be more comfortable discussing issues with a peer who is experiencing the same challenges. Peer support is a system of reciprocal help between individuals which is based on respect, shared responsibility and empathy through shared experiences of emotional and psychological distress (Mead et al, 2001). Collins & Repinski (1994) assert that relationships between students explore reciprocity, trust and conflict resolution skills. Sharing one's distress may help to alleviate the burden especially when there is trust amongst the students. The peer support seeking behaviour in this study is supported by the findings in a 3-year longitudinal study conducted by Lo (2002) on methods of reducing tension in nursing

students. The students in the study indicated 'peer support' assisted them with reducing personal stress, as they were able to vent to their feelings of distress.

Educators and clinical staff reported that they allowed students to self-explore in order to increase confidence in themselves. Self-exploration is the process whereby a student examines and analysis his/hers own unrealized intellectual capabilities (www. Merriam Webster.com). Students in this study may have felt that they were supported, as educators and clinical staff demonstrated trust in their ability to acquire knowledge, skills and attitude independently. Through this experience students may have gained insight into how to address their own needs.

Students were encouraged by both educators and clinical staff to use discretion when seeking role models in the clinical setting, as some staff displayed negative behaviour. This is concerning as students must learn professional behaviour through emulation of professional nurses. Although the educators may have perceived this to be supportive, the acknowledgement that some experienced nurses may not be ideal role models may in itself be distressing for students. However, students need to be treated with honesty and integrity, and this may mean that students perceive the educator as truthful as she is able to identify shortcomings in the nursing profession. The educators' actions may signify support to students. According to Morrissette & Doty-Sweetnam (2010), educators can nurture a respectful relationship with students when they are sensitive to their interactions with students.

The use of written communication to support students included the writing of incident reports, which clinical staff encouraged. Students wrote reports about incidents such as violence, abuse, medication errors to name but a few - which may have transpired

during the clinical placements. The knowledge that someone else may peruse the report may be reassuring and comforting for students who are distressed. The writing of incident reports may also have a cathartic function, where students can write about their distress. Catharsis is the purging of unwanted emotions by performing acts to ventilate emotions such as writing about incidents. Bush, Baumeister & Phillips (2001) have found that the cathartic nature of venting emotions does not necessarily reduce the adverse effects of stressful emotions.

Clinical staff alluded to treating students as equal to themselves. Acts described by clinical staff to demonstrate their show of equality included the inclusion of students in special events that were organised by the facilities. The result thereof as perceived by the clinical staff, was that students felt comfortable enough to express themselves. While student experiences of being invited to special events were not explored, as the students themselves did not. The researcher interprets these acts of inclusion as rewards bestowed on students for being part of the work force or as a clinical staff member reported: *"they work as hard as we do"*.

Coping is the process of managing emotions and influencing the conditions and processes that bring them about (Lazarus & Cohen-Charash, 2001). In this study students mostly employed problem-focused coping to help them to cope in the mental health care environment. Problem-focused coping is also known as direct coping and refers to when an individual directs coping efforts to manage or alter the problem causing the distress (Lazarus & Folkman, 1984). A student may utilise problem-focused coping strategies when she feels that she can do something constructive about the stressor. This finding is consistent with Pryjmachuk and Richards (2007) study on inter-branch differences between adult, mental health,



children and learning disability nurses in terms of coping. Mental health nursing students made use of problem-focused coping rather than emotion-focused coping.

Lazarus (2000) asserts both problem-focused coping and emotion-focused strategies are interdependent, one supplementing the other in the coping process. So while students in this study may have mostly used problem-focused coping strategies, they also used emotion-focused strategies to cope. Emotion-focused strategies refer to cognitive processes aimed at decreasing emotional distress and includes strategies such as avoidance, distancing and minimisation (Lazarus & Folkman, 1984).

Certain students, however, displayed negative coping - mostly in response to the negative attitude of the clinical staff towards them. The negative coping included defensive coping such as disengagement from the experience. By blocking the experience, students created an invisible barrier around them which may have served to protect them from the overwhelming emotions experienced. These findings are supported by Freeburn and Sinclair (2009) who conducted a study on personal stress experienced by mental health students in Ireland. The participants utilised negative coping mechanism which included denial, avoidance amongst others to cope with the mental health experience.

Problem-focused coping includes environmental focus on coping and also includes strategies directed to the self (Lazarus, 1999). The environmental focus in this study was that students utilised social support, namely friends and family to cope with the experience. According to Thoits (1996) individuals (students) will seek others (friends, family) who they believe can empathise with their situation (mental health experience) and are socio-culturally similar.

The findings related to student coping in this study also suggest that students utilised the sense of self through intrapersonal communication, to enable them to cope within

the mental health care environment. They were able to deal with some of their issues on their own. Students were positive about coping in the mental health care environment. They alluded to accessing intrinsic resources by means of internal discourse to assist them to cope. These included the use of prayer. The use of prayer to manage negative emotions has been studied by different researchers (Banziger, van Uden & Janssen, 2008; Bade & Cook, 2008) who assert that prayer helps individuals to calm down, gain a sense of comfort and decrease fear. Another way prayer helped students to manage negative emotions in this study, was by actively stopping or as Sharp (2010) asserts 'zoning out', negative stimuli from entering cognitive awareness

*"It's almost like (the) serenity prayer...Keep ...asking God every day...please grant me to accept the things that I cannot change. So that's the same...line that I say to myself every morning when I get up"*

This finding was supported by Sharp (2010) in a study conducted to determine how prayer assists individuals to manage negative emotions. Findings suggest that prayer is an imaginary social support interaction that provides individuals with resources to help them manage negative emotions.

Other problem-focused coping included cognitive restructuring, which is when students modified their thoughts, ideas and beliefs about the negative mental health experience to think more positively which aided coping (van Vuuren, 2012). Cognitive restructuring was aided by students engaging in self-talk, which assisted them in identifying their emotions and placing them within context of the event. Whilst students alluded to *"having a lifetime of dealing with events"*, the assumption is that they were cognisant of coping strategies which would assist them to cope within the stressful mental health care environment.

## **Summary**

Coping according to students, educators and clinical staff took place by means of internal and external discourse, with some students employing intrapersonal communication in the form of problem-focused coping to cope with the experience. Interpersonal communication between educators, clinical staff and students was limited, which resulted in the mental health care environment being appraised as mostly negative.



**Table 4.12. Summary of vertical themes relating to emotional support needs of students per participant group and concluding statements**

STUDENT NURSES	EDUCATORS	CLINICAL STAFF	CONCLUDING STATEMENTS BASED ON HORIZONTAL THEMES
VERTICAL THEMES AND RELATED CATEGORIES			
THEMES; CATEGORIES	THEMES; CATEGORIES	THEMES; CATEGORIES	
<p>HEI</p> <p><b>THEME: 8A</b> Although students were aware of existing support services in the HEI, they proposed a multidisciplinary team approach, including academic and practice staff that possessed appropriate knowledge, skills and attitude who served as role models to support students in the mental health care environment. Accessible counselling programmes across the four-year nursing programme is required to assist students to cope</p> <ul style="list-style-type: none"> <li>- Students needed an accessible, independent nurse or psychologist who was experienced, knowledgeable and skilled and possessed appropriate attitude</li> <li>- A support person who knew more than one language, of similar age, who possessed attitude was identified by students</li> <li>- Available, lecturer with interpersonal skills to conduct support meetings</li> <li>- Clinical supervisors as they are available with sound interpersonal skills</li> <li>- Lecturer interest in wellbeing, value of role models and skills teaching to raise emotional support awareness</li> <li>- Weekly on-going supportive counselling - namely debriefing, across the four-year programme</li> </ul>	<p><b>THEME: 4B</b> Educators were unaware of structured student support services but identified informal support within the HEI and clinical services</p> <ul style="list-style-type: none"> <li>- Educators were unaware of structured support services</li> <li>- Educators identified their role, the clinical services and residence committees in providing student support, albeit informally</li> </ul> <p>HEI</p> <p><b>THEME: 5B</b> A multidisciplinary team approach was identified with staff from the HEI rendering a structured programme for student nurses with access to resources.</p> <ul style="list-style-type: none"> <li>- An independent department and structured program</li> <li>- Available nurse with knowledge, skills and attitude to assist students to deal with the emotional experience</li> <li>- Access to available support via telecommunication</li> <li>- A multidisciplinary team approach</li> </ul>	<p><b>THEME:7C</b> Their awareness of support services was limited as most clinical staff were uncertain, while others recognised a lack of support services due to limited structured support; as a result clinical staff mainly used informal support, including peer support, which impacted negatively on referral of students who needed intervention</p> <ul style="list-style-type: none"> <li>- Unawareness of support services by clinical staff impacted negatively on referral of students</li> <li>- Recognition of lack of support, the differences between student and staff support and the adverse effect on the students</li> <li>- Access for emotional support in the clinical setting followed a hierarchal system of reporting and intervention</li> <li>- Orientation and introduction of students included safety precautions</li> <li>- Same reporting procedure of incidents for both students and staff although support given differed</li> <li>- Clinical supervisors identified as student support persons</li> <li>- Reliance on clinical staff for personal and professional support as they offered support, in the absence of the clinical supervisors</li> <li>- Students perceived to be supportive towards each other which was encouraged by clinical staff</li> </ul>	<p>Awareness of structured support was limited or absent resulting in the use of informal support.</p> <p>HEI</p> <p>A multidisciplinary collaborative team approach with accessible and available academic and clinical staff that possess knowledge, attitude and skills offering psychological interventions, structured programmes to enable student coping within the mental health care environment.</p> <p>CLINICAL SETTING</p> <p>Collaborative liaison between the HEI and clinical settings offering formal training on student supervision, mentoring and counselling services.</p>

<p><b>CLINICAL SETTING</b></p> <p><b>THEME:9A Effective collaboration between HEI and clinical service, with clear policies and procedures on how to support students. Mentoring programmes and counselling services to support students in the mental health care setting</b></p> <ul style="list-style-type: none"> <li>- Liaison between the HEI and clinical setting to establish an effective relationship to support students</li> <li>- Clear policies and procedures in place for orientation and self-care of students in the facilities</li> <li>- Mentors who had mentorship programmes which included initial student orientation</li> <li>- Involved clinical staff who educate students</li> <li>- Accessible assessment and counselling service for students</li> </ul>	<p><b>CLINICAL SETTING</b></p> <p><b>THEME:6B Closer liaison between HEI and clinical services and training by clinical staff to take ownership of their role in the supervision of students in the mental health care setting</b></p> <ul style="list-style-type: none"> <li>- Liaison between the HEI and services to ensure services taking ownership of students</li> <li>- Clinical staff need training to fulfil their supervisory role</li> </ul>	<p><b>HEI</b></p> <p><b>THEME: 8C The need for a support centre with a range of multidisciplinary services which should also be accessible through telecommunication. Physical orientation to the settings was identified.</b></p> <ul style="list-style-type: none"> <li>- Support centre with a range of services which adopted multidisciplinary team approach.</li> <li>- Specific telecommunication services and physical orientation to the settings was identified</li> <li>- Support centre with a person to help students confidentially</li> <li>- Accessible and available psychologist to talk to</li> <li>- Understanding experienced lecturers and empathetic mentors</li> <li>- A helpline manned by a counsellor who listened to students anonymously</li> </ul> <p><b>CLINICAL SETTING</b></p> <p><b>THEME: 9C The need for structured student support by an independent support person, who liaises with the HEI, and orientates and give feedback to students to create a sense of belonging</b></p> <ul style="list-style-type: none"> <li>- Appointment of independent support person</li> <li>- Support needed to be formalised</li> <li>- Clinical staff support role included the need to protect, mentor, and debrief students</li> <li>- Site visit of institution prior to their clinical placement</li> <li>- Liaising between the clinical setting and the HEI</li> <li>- Orientation of students by registered nurses for students to create a sense of belonging</li> <li>- Timeous feedback</li> <li>- Staff and students support groups</li> </ul>	
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#### 4.4.3 Emotional support needs

Both educators and clinical staff were unaware of formal support services offered for student nurses. While some educators were aware of the university support services, they reported being unable to access the services. This may be that educators did not have previous experience in accessing student support services either for themselves or students, and thus did not know the referral process. As alluded to earlier, student support services may not be utilised by nursing students as they spend more time in the clinical services than at the university. However, support needs identified by all the participants included a multidisciplinary approach to student support with specific individuals, namely a nurse or a psychologist to offer the support services. The nurse may serve as the support person for the educators as well, as they were recognised by students and clinical staff for their clinical and educational expertise. This would imply that the educators would be able to support students, as they understand student's academic experiences due to the nature of their function. They would also have clinical expertise as they are registered nurses who may have worked in mental health care settings. Students affirmed the clinical staff's perception of having experience in nursing to be able to offer support, when they identified a psychologist with "*experience in nursing*" as a support person. It appears that the participants felt that if one has similar socio-cultural experiences then the individual can offer support, as they would know what the student is experiencing.

All participants identified a multidisciplinary team approach to meet the students' emotional support needs. A multidisciplinary team approach refers to services offered by a group of health care professionals who have different areas of expertise and who work together in a coordinated way ([www.encycl.co.uk](http://www.encycl.co.uk)). The multidisciplinary

team would consist of specific identified individuals such as nurses, psychologists and educators. Participants however felt that these individuals needed to be independent, meaning that they were not employed to do other tasks at the university besides student support. The criteria would include being of similar age to the students and being conversant in more than one language. As the average age of students in the school of nursing is 35 years (University of the Western Cape, 2009), the identified person would have to be a young adult. The interpretation thereof is that participants may feel that someone who is of similar age will be able to identify with what they are experiencing.

Stanley and Burrows (2001), assert that through verbal descriptions a student is able to articulate the subjective experience of emotions. Language would thus be important during the communication process, where students articulate their emotional experiences and the specified persons respond with support. Communication was also identified in the formation of the interpersonal relationships - with the necessary knowledge, skills and attitude to support students in the mental health care environment.

All participants felt that there should be a liaison between the HEI and clinical settings to support students. It appears from the results that clinical staff and educators assisted students by communicating with them. However, given that all participants identified the communication between the HEI and clinical setting, it appears that communication is not taking place at an institutional level but only amongst individuals (students, educators and clinical staff). This result is concerning as policies and procedures are designed and developed at an institutional level, and if communication between the HEI and clinical settings is not occurring – how will this influence student support?

Whilst clinical staff identified the need for a support centre for student support, students felt that there should be mentors who offered a mentoring programme to support students in dealing with the mental health experience. Different services were also identified such as counselling, which would mean that if students are traumatised they will be able to access assistance promptly rather than to wait for an appointment at the counselling centre of the HEI or have to rely on clinical staff to assist in the face of shortage of clinical staff.

#### **4.5 SUMMARY**

The negative emotions that students experienced during their placement in the mental health care setting can be ascribed to the result of the interplay between the student and the environment. Lazarus and Folkman (1984) assert the individual (student) is not a mere recipient of the environmental demands but rather actively engages with and within the environment, appraising and modifying the environment based on personal choices, values, abilities and preferences.

While students reported mostly negative emotions and experiences, clinical staff and educators made reference to how they supported students to cope by communicating and being available to support students in the mental health care setting.

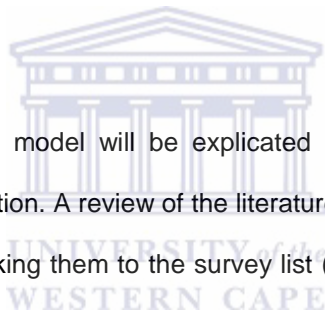
The results showed that there was limited collaboration and liaison between the HEI and the mental health services. Students appeared to rely on both clinical staff and educators to meet their need of belonging. Educators and the clinical staff appeared to be aware of students' non-verbalizations, however they continued to offer support on what they perceived to be the students'. The students' needs were thus not met, as there was a disjuncture between what the students felt they required as support and what educators and clinical staff were offering.



In order to offer students emotional support, student and environmental variables must be considered. Kotze (1998) alludes to the objective (external) and the subjective or life-world in which the student lives. Whilst the objective world is in part what exists out there, the student will explore but incorporate a part of it into his/her life world.

All participants' results and discussions relating to students' emotional responses, coping and support needs were identified with the aim of the developing of an emotional support model to facilitate the process whereby students will assume accept responsibility for meeting their own emotional support needs once the identified deficits are addressed.

In chapter five, a description of the model will be explicated by way of concept development, classification and definition. A review of the literature will assist with the definition of the main concepts by linking them to the survey list (Dickoff et al, 1968) to show its relevance to emotional support.



## CHAPTER 5

### THE DEVELOPMENT AND DESCRIPTION OF AN EMOTIONAL SUPPORT MODEL FOR STUDENTS WORKING IN MENTAL HEALTH CARE SETTINGS

#### 5.1 INTRODUCTION

Chapter four focused on the results, the interpretation thereof and an integrated discussion of the results which emanated from focus group discussions with student mental health nurses and semi-structured interviews conducted with educators and clinical staff. The findings were discussed according to the themes and categories which emerged from the data as well to and re-contextualise with a literature control. Concluding statements were formulated based on the horizontal themes which cut across the group participant responses.

The process of model development in this study followed the process described in chapter 3: 3.5 according to Chinn & Kramer (2004), Walker & Avant (2005) and Dickoff et al (1968).

Main concepts were identified from the concluding statements in order to create conceptual meaning. Conceptual meaning provided a foundation for developing an emotional support model for student nurses working in mental health care settings and, to achieve the fifth objective of this study which was to:

*develop a model of emotional support for students working in mental health care settings based on students' self-identified emotional needs, the student's emotional needs as identified by the education and clinical staff and the existing strategies of student support.*

The focus of this chapter is concept identification (step one), model development (step two), model description (step three) and the development of guidelines (step four) for the implementation of the model. Concept identification includes the identification of main and related concepts. Model development includes the classification and definition of the concepts. Model description is structured according to the following sub-headings: overview of the model, context, purpose and assumptions on which the model is based. The structure, definition, relation statements and a process description of the model is given. Guidelines for operationalization or implementation in both the HEI and the mental health care setting are developed.

## **5.2 CONCEPT DEVELOPMENT**

Concepts are mental images of a phenomenon which help to organise or categorise environmental stimuli (Walker & Avant, 2005). The process of concept development involves identifying (step one), classifying and defining concepts (step two).

Identifying, classifying and defining the main concepts facilitated the creation of conceptual meaning which is a theory-building approach. According to Chinn & Kramer (2004), conceptual meaning is the process whereby individuals use ideas, thoughts or feelings to represent their experiences which would not likely to be expressed through the definitions. These thoughts are expressed in discipline-specific or everyday language. Whilst conceptual meaning is complex, it displays a mental picture of what the phenomenon is like and how it is perceived in human experience- the context determines the meaning given.

### **5.2.1 Step one: Concept identification**

Identifying concepts was guided by the purpose of the study and also expressed the values related to the purpose (Chinn & Kramer, 2004). Values that influenced the identification of concepts included the researcher's beliefs about the nature of nursing, the person, society as well as the environment and health. Concepts help the individual to identify how experiences are alike by categorising all the things that are similar about them. Concepts and main concepts were classified by means of the survey list of Dickoff et al (1968) (see 5.2.2.1).

#### **5.2.1.1 Identifying concepts and main concepts**

Guided by the purpose of the study, concepts were identified by the 'searching out' of words and groups of words that represent the phenomena and their related actions (Chinn & Kramer, 2004) in the seven concluding statements. A total of 22 concepts were identified. These concepts were further synthesised by means of examining the similarities and differences which resulted in the final deductive formation of six main concepts. These main concepts were used to develop an emotional support model for students working in mental health care settings. The *main concepts* as depicted in Table 5.1 are:

1. Positive work environment
2. Positive self-concept
3. Effective communication
4. Collaboration between HEI/clinical setting
5. (a) Formal and (b) informal supportive intervention strategies
6. Academic and professional development

The main concepts were structured using the transactional model of stress and coping of Lazarus and Folkman (1984) as a framework (see table 5.1) to capture the emotional responses, coping resources and support needs of students working in mental health care settings.



**Table 5.1: Process of identifying and classifying concepts and main concepts**

TRANSACTIONAL MODEL OF STRESS AND COPING	CONCLUSION STATEMENTS BASED ON HORIZONTAL THEMES	CONCEPTS	MAIN CONCEPTS
<b>EMOTIONAL RESPONSES</b>	<p>Students experienced the lack of a sense of belonging which was influenced by staff attitude, perceived unpreparedness of students, lack of role modelling and the stigmatisation and nature of the work environment which induced fear, anxiety and traumatisation. Distrust resulted in lack of communication which could have resolved the perceived lack of support</p> <p>The strong influence of the sociocultural background of students, family responsibility and expectations influenced their experience. This experience was positive when knowledge gained could resolve preconceptions about mental health</p> <p>Student's age, affective state and knowledge about mental health influenced self-awareness and self-diagnosis leading to self-management and the resultant psychological responses.</p>	<p>Sense of belonging Positive staff attitude Preparedness of students Role modelling Destigmatisation Positive work environment Trust Effective communication Support</p> <p>Cultural competency Acquisition of knowledge</p> <p>Self-awareness</p>	<p><b>1. Positive work environment</b> - Positive staff attitude - Cultural competency - Role modelling - Destigmatisation</p> <p><b>2. Positive self-concept</b> - Sense of belonging - Self-awareness - Trust - Self confidence</p> <p><b>3. Effective communication</b> - Constructive communication</p> <p><b>5 (a) Informal supportive intervention strategies</b> - Social support</p>
<b>COPING RESOURCES</b>	<p>Students utilised social support, emotional self-care activities and knowledge to cope when defensive and negative behavioural strategies did not improve their ability to cope; whilst educators and clinical staff availed themselves for student consultation and role modelled constructive communication to allay student fears and increase student self-confidence.</p>	<p>Social support Emotional self-care activities Acquisition of knowledge Availability of educators and clinical staff Constructive communication Role modelling Self confidence</p>	<p>- Emotional self-care activities - Availability of educators and clinical staff</p> <p><b>6. Academic and professional development</b> - Acquisition of knowledge - Preparedness of students</p>
<b>CONTEXTUAL SUPPORT NEEDS</b>  i) HIGHER EDUCATION INSTITUTION	<p>Awareness of structured support was limited or absent resulting in the use of informal support.</p> <p>HEI</p> <p>A multidisciplinary collaborative team approach with accessible and available educators and clinical staff who possess knowledge, attitude and skills offering psychological interventions, as well as structured programmes to enable student coping within the mental health care environment.</p>	<p>Formal support Multidisciplinary collaborate team approach Accessibility and availability of educators and clinical staff Knowledge, skills and attitude Psychological interventions Structured programmes</p>	<p><b>i) HEI</b></p> <p><b>4. Collaboration between HEI/clinical setting</b> -Multidisciplinary Collaborative team approach</p> <p><b>5 (a) Informal supportive intervention strategies</b> Accessible and available educators and clinical staff</p> <p><b>5 (b) Formal supportive intervention strategies</b> - Psychological interventions - Structured programmes</p> <p><b>6. Academic and professional development</b> - Knowledge, attitude, skills</p>

ii) CLINICAL SETTING	<b>CLINICAL SETTING</b> Collaborative liaison between the HEI and clinical settings offering formal training on student supervision, mentoring and counselling services.	Collaborative liaison between HEI/clinical setting Mentorship and counselling services Supervisory training	<b>ii) CLINICAL SETTING</b>  <b>4. Collaboration between HEI/clinical setting</b> - Collaborative liaison between HEI/clinical setting  <b>5. (b) Formal supportive intervention strategies</b> - Mentoring and counselling services  <b>6. Academic and professional development</b> - Supervisory training
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## 5.2.2 Step two: Classification and definition of concepts

Concepts were classified according to the survey list developed by Dickoff et al (1968) and defined according to dictionary and subject definitions in the section that follows.

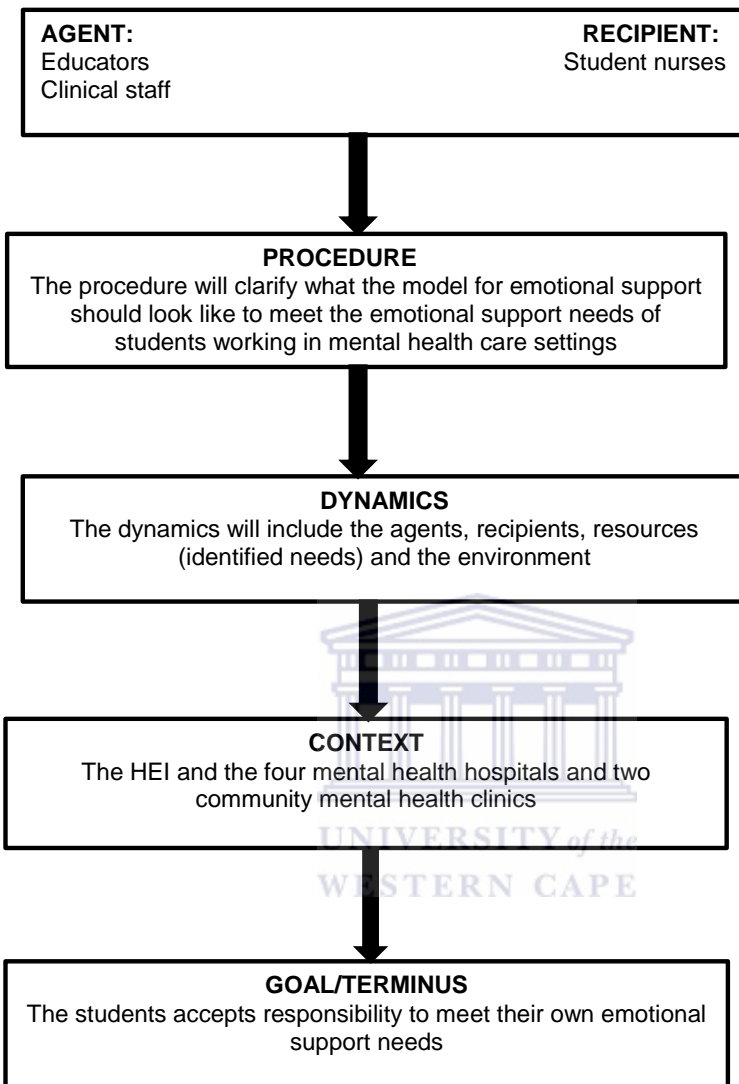
### 5.2.2.1 Classification of the main concepts for model structure

The main concepts of the study identified in table 5.1 were classified according to the survey list developed by Dickoff et al (1968). The survey list highlights six activity aspects which included ways of looking at emotional support in the hope of revealing different features. All aspects of the activity list are important and should thus be taken into account in order to obtain a full exploration of the experience of emotional support as perceived by students, educators and clinical staff working in mental health care settings. Six questions relating to the activity aspects are used to survey activity and these include:

- 1) Context - *In what context is the activity performed?*
- 2) Agent - *Who or what performs the activity?*
- 3) Recipient - *Who or what is the recipient of the activity?*
- 4) Procedure - *What is the guiding procedure, technique or protocol of the activity*
- 5) Dynamics - *What is the energy source for the activity?*
- 6) Goal - *What is the end point of the activity?*

The researcher's reasoning map related to the survey list as depicted in figure 5.1 below, will serve the purpose of clarifying how the main and related concepts were classified.





**Figure 5.1: Researcher’s reasoning map for clarification of classifying the concepts**

The systematic ordering of the concepts is depicted in Table 5.2 and is followed by an exposition of the concepts according to the six elements of the survey list.

**Table 5.2: Concept classification**

Main concepts identified with related concepts	Arrows depicting logical arrangement from concept identification to concept classification	Concept classification (Dickoff et al. 1968)
<p><b>Positive self-concept</b></p> <ul style="list-style-type: none"> <li>- Sense of belonging</li> <li>- Self-awareness</li> <li>- Trust</li> <li>- Self confidence</li> </ul> <p><b>Positive work environment</b></p> <ul style="list-style-type: none"> <li>- Positive staff attitude</li> <li>- Cultural competency</li> <li>- Role modelling</li> <li>- Destigmatisation</li> </ul> <p><b>Academic and professional development</b></p> <ul style="list-style-type: none"> <li>- Acquisition of knowledge</li> <li>- Knowledge, skills and attitude</li> <li>- Preparedness of students</li> <li>- Supervisory training</li> </ul> <p><b>Effective Communication</b></p> <ul style="list-style-type: none"> <li>- Constructive communication</li> </ul> <p><b>Formal and informal supportive intervention strategies</b></p> <ul style="list-style-type: none"> <li>- Social support</li> <li>- Emotional self-care activities</li> <li>- Psychological interventions</li> <li>- Accessibility and availability of educators and clinical staff</li> </ul> <p><b>Collaboration between HEI/clinical setting</b></p> <ul style="list-style-type: none"> <li>- Multidisciplinary team approach</li> </ul>		<p><b>Agent:</b> Educators and clinical staff</p> <p><b>Recipient:</b> Student nurse</p> <p><b>Context:</b> Higher education institution Mental health care setting - hospitals/community clinics</p> <p><b>Goal/terminus</b> Students accepts responsibility to meet their own emotional support needs</p> <p><b>Procedure:</b> Interpersonal communication process</p> <p><b>Dynamic:</b> Collaborative liaison</p>

### **5.3 EXPOSITION OF THE IMPLEMENTATION OF THE SURVEY LIST**

A brief explanation is given below of how the concepts and the main concepts were used to answer the questions in the survey list. In other words, the arrows of Table 5.2 now points back/in opposite direction.

#### **5.3.1 Context:**

In what context will the model of emotional support be developed and described? In this study there are two contexts. The first context referred to the specific HEI where the study was conducted. The second context is the specific mental health care settings which include the four psychiatric hospitals and community mental health clinics where students worked during clinical placements. Both contexts provide mental health experiences as students need to integrate theory (HEI) and practice (mental health care setting). The assumption is then that the participants of this study alluded to events, behaviours and actions which occurred in both contexts to give a holistic view of the total sum of mental health experiences. The main concept identified during the classification process pertaining to the context is:

- Positive work environment

#### **5.3.2 Agent**

Who will be responsible for the emotional support of students working in the mental health care setting? In this model the agent initially is the educators and clinical staff who are responsible for the education and training of nurses. The students will eventually also becomes the agent when they assume responsibility for their own emotional support needs when the identified deficits are addressed. The main concepts identified during the classification process pertaining to the *agent* are:

- Positive work environment

- Academic and professional development
- Formal and informal intervention strategies

### 5.3.3 Recipient

Who will benefit from a model of emotional support? In this model, the mental health students are the recipients who need to have their emotional support needs met. However, when students' emotional support needs are met then both the HEI and mental health clinical setting would benefit as the students would accept the responsibility for meeting their own emotional support needs. The main concepts identified during the classification process pertaining to the *recipient* are:

- Positive self-concept
- Academic and professional development
- Formal and informal intervention strategies



### 5.3.4 Procedure

What will the techniques, procedures and protocols associated with a model of emotional support for students be? Dickoff et al (1968) assert that procedure refers to the path, steps or general patterns on the way to the accomplishment of the goal. The procedure, namely an interpersonal communication process, by way of the phases namely orientation, working and termination is envisaged to realise the goal, viz. the students accepting responsibility for meeting their own emotional support needs.

The main concept identified during the classification process pertaining to the *procedure* is:

- Effective communication process/interpersonal relationship

### 5.3.5 Dynamics

What is the energy source (motivation) of the activity? In order for students to be supported emotionally, the process of a collaborative liaison between the agent, recipient and the context needs to occur. The main concepts identified during the classification process pertaining to the *dynamics* are:

- Academic and professional development
- Formal and informal supportive intervention strategies
- Collaboration between HEI/clinical settings

### 5.3.6 Terminus

What will the aim of developing an emotional support model for student nurses working in mental health care settings be? The aim of the model is to facilitate the emotional support for students working in mental health care settings, so that the students can develop a positive self-concept which would enhance student learning. The main concept identified during the classification process pertaining to the *terminus* is:

- Positive self-concept

## 5.4 DEFINITION OF CONCEPTS

Main concepts are defined by way of dictionary and subject definitions after which both definitions are synthesised to give a synopsis of the definitions. Defined concepts are contextualised for this study and give meaning to the various aspects within the model of emotional support for student nurses working in mental health care settings. The related concepts are referred to but will be integrated in the discussion of the structure ( 5.9) and process of the emotional support model (5.11).

### **i) Positive work environment**

The first main concept, positive work environment, has related concepts which are positive staff attitude, cultural competency, role modelling and destigmatisation.

#### **Dictionary definition of the concept: positive work environment**

The Oxford Dictionary (2007), declare that positive refers 'to consisting in, characterised by or expressing the presence of possession of features or qualities; of an affirmative nature'. The online Merriam Webster dictionary (<http://www.merriam-webster.com>) defines positive as 'affirming the presence of a suspected condition to be present; thinking about the good qualities of something'.

Work environment is defined as 'a place at which a person works' (Oxford Dictionary, 2007).

#### **Subject definition of the concept: positive work environment**

A positive work environment is defined in this study as the mental health care setting (psychiatric hospitals and community mental health clinics) where students work to acquire clinical experience which is characterised by educators and clinical staff who display a positive attitude towards students.

#### **Summary**

A positive work environment is the total learning environment which includes the HEI and the mental health care setting where interactions with students, educators and clinical staff are characterised by affirmation and good qualities relating to positive staff attitude, cultural competency, role modelling and destigmatising mental health by educators and clinical staff. A positive environment also respectfully challenges students to grow thus allowing for difficult experiences and being there to guide and support.

## **ii) Positive self-concept**

The second concept, namely positive self-concept, has related concepts which are sense of belonging, self-awareness, trust and self-confidence.

### **Dictionary definition of the concept: positive self-concept**

The Oxford Dictionary (2007:2742) defines the self-concept as “a person’s conception or idea of him/her”. The Merriam Webster online dictionary (<http://www.merriam-webster.com>) defines the self-concept as having a mental image of or on oneself.

### **Subject definition of the concept: positive self-concept**

Antai-Ontong (2008) defines the self-concept as ‘the beliefs and feelings about the self which frames life experiences and perceptions of the world’. Louw and Du Plooy-Cilliers (2003) assert that a positive self-concept is the positive impression that one has of him/her as it is the reference point from where the student communicates both intrapersonally and interpersonally. The self-concept can also be seen as a collection of beliefs about one’s nature, qualities and behaviour (Weiten, Dunn and Hammer, 2012).

### **Summary**

A positive self-concept refers to the affirming impressions students have about themselves which affects how they interact with the self in internal world and with others in the external world and that contributes to their coping in the mental health care setting.

## **iii) Effective communication**

The third concept effective communication has a related concept which is constructive communication.

### **Dictionary definition of the concept: effective communication**

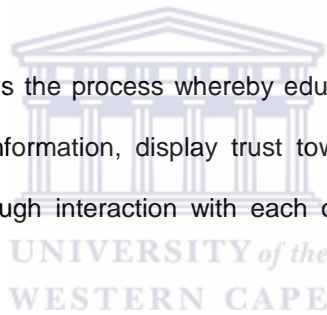
Effective is defined as producing a desired or decisive effect (<http://www.merriam-webster.com>). The Concise Oxford Dictionary (2006: 236) defines communication as 'the action of sharing or exchanging information or ideas'. Communication is also defined as the process by which information is exchanged or transmitted between individuals (<http://www.merriam-webster.com>).

### **Subject definition of the concept: effective communication**

Communication is defined as the process whereby people interactively create, sustain and manage meaning through the transactional between themselves and the environment (Louw & Du Plooy-Cilliers, 2003).

### **Summary**

Effective communication is defined as the process whereby educators, clinical staff and student's share or exchange information, display trust towards one another, actively listen, spend time with through interaction with each other in the sense-making process.



### **iv) Collaboration between HEI/clinical setting**

The fourth main concept, namely collaboration between HEI/clinical setting, has a related concept which is multidisciplinary team approach. However, the concept 'collaborative liaison' was deductively analysed from a combination of meanings to convey the dynamics (energy) in the study to attain the goal of the activity. These concepts will also be defined as they are pertinent concepts in the explanation of the description of the model.

### **Dictionary definition of the concepts: collaboration and collaborative liaison between HEI/clinical setting**



Collaboration is defined as working together jointly with others or together (<http://merriam-webster.com>). In the Concise Oxford Dictionary (2006: 228) collaboration (an adjective) is defined as “to work jointly on an activity”.

The online Merriam-Webster dictionary (<http://merriam-webster.com>) defines liaison as communication aimed at establishing and maintaining mutual understanding and cooperation.

**Subject definition of the concept: collaboration**

Collaboration is a process whereby individuals or groups share information and resources for their mutual benefit. They may also alter or synergise the activities and envision a joint future (Lind & Newton, 2001).

**Summary**

Collaboration is the process whereby students, educators and clinical staff work together, with understanding and mutual cooperation in a shared environment (HEI and clinical setting) to achieve the ‘common goal’ of supporting students emotionally in the mental health care setting.



**v) Formal and informal supportive intervention strategies**

The fifth main concept, namely formal and informal supportive intervention strategies has related concepts which are social support, emotional self-care activities, psychological interventions and accessibility and availability of educators and clinical staff.

**Dictionary definition of the concept: formal and informal supportive intervention strategies**

The Concise Oxford Dictionary (2006:457) defines formal as ‘being in accordance with the rules of convention/having a conventionally recognised structure or set of rules’. Informal is defined as relaxed and unofficial, not formal (Concise Oxford

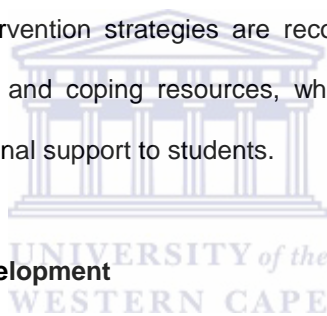
Dictionary, 2006:598). Supportive is defined as providing or encouraging support/mental comfort (Oxford Dictionary, 2007:3116). Intervention strategies are defined as the process of action in a plan designed to achieve a long term aim (Concise Oxford Dictionary, 2006).

**Subject definition of the concept: formal and informal supportive intervention strategies**

Formal and informal intervention strategies are coping resources for example psychotherapy or peer support respectively, which enable an individual to cope whilst working in a mental health care setting (Ross & Altmaier, 1994).

**Summary**

Formal and informal supportive intervention strategies are recognised counselling services and the self-care activities and coping resources, which are planned or unplanned, aimed at providing emotional support to students.



**vi) Academic and professional development**

The sixth concept, namely academic and professional development, has related concepts which are acquisition of knowledge, knowledge skills and attitude, preparedness of students and supervisory training.

**Dictionary definition of the concept: academic and professional development**

The Concise Oxford Dictionary (2006:5) defines academic as 'relating to or of education and scholarship'. Professional refers to 'being engaged in a profession especially one that requires advanced knowledge' (Oxford Dictionary, 2007:2360). Development is defined as 'a specific state of growth or advancement' (Concise Oxford Dictionary, 2006:321).

**Subject definition of the concept: academic and professional development**

Academic and professional development in mental health refers to the specific education and training of nursing students, educators and clinical staff which is focused on developing or growth of the students involved.

### **Summary**

Academic and professional development thus means the growth of all the stakeholders (students, educators and clinical staff) within the nursing profession through emotional support and knowledge, skills and attitude, preparation of students and supervisory training.

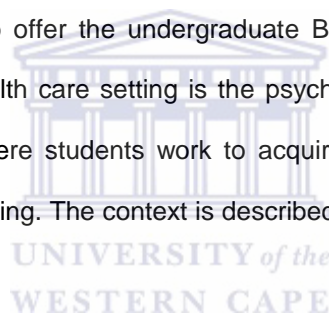
## **5.5 OVERVIEW OF THE MODEL**

The discussion of the overview of the model is based on the model depicted in figure 5.2 which serves as a reference framework for the emotional support of students working in mental health care settings. It became evident throughout the study, that the students experienced a range of emotional responses within the person/mental health care environment transaction. Some students appraised the mental health care environment as positive, although mostly negative organisational and psychological responses were elicited. Student coping occurred through the use of adaptive (mostly on an intrapersonal level) and maladaptive coping strategies. A range of support needs were identified based on the strategies that participants used to support themselves (students), the support of others (educators and clinical staff) and the intervention strategies participants deemed to be emotionally supportive - in order for them to cope whilst working within the mental health care environment. The emotional support needs that were identified focused on the student as a person (the self-concept) within a psychological realm, and the emotional support needs within an organisational context (HEI and mental health care setting).

The emotional support model is a transactional model as it depicts the interaction between the student, clinical staff (mental health care setting) and educators (HEI) - to realise the goal of supporting students to assume responsibility for their own emotional support needs. It is also highly complex and therefore challenging to include all the aspects within the self and the environment which may be deemed emotionally supportive. The model therefore depicts the process of emotional support and anticipating that it might be viewed as a limited reflection of reality.

### **5.6 CONTEXT OF THE MODEL**

The context of this model is the HEI and the mental health care settings. The HEI is a university in the Western Cape who offer the undergraduate B Nursing degree in nursing to students. The mental health care setting is the psychiatric hospitals and community mental health clinics where students work to acquire knowledge, skills and attitude about mental health nursing. The context is described in detail in chapter 1.



### **5.7 PURPOSE OF THE MODEL**

The purpose of the model is to serve as a reference framework for educators and clinical staff in the HEI and mental health care settings in the Western Cape metropole region respectively, to facilitate the emotional support of students working in mental health care settings to take responsibility for meeting their emotional support needs. It is anticipated that initially educators and clinical staff would facilitate the process until the students assume responsibility for meeting their own emotional support needs. This may be achieved by collaborative liaison between the educators, clinical staff and students. The purpose of the model is realised through the guidelines for its operationalization.

The purpose of the model within the discipline of nursing is for it to be a practice model which adds to the professional body of nursing knowledge, in the form of an emotional support focus for students working in the mental health care setting.

### **5.8 ASSUMPTIONS OF THE MODEL**

The emotional support model for student nurses working in mental health care settings is based on the following philosophical assumptions taken from the Nursing Accompaniment Theory (Kotze, 1998), as discussed in Chapter 1 and serves as a point of departure.

- i) The model is based on the assumption that emotional support for students takes the total support needs from an organisational, social, physiological and psychological perspective into account and this represents the student's total learning environment within a mental health context.
- ii) The student nurse is a unique multidimensional total human consisting of body-psyche-spirit in interaction with the environment.
- iii) The environment of the student includes the external or objective world and the internal or subjective/life world.
- iv) The life world of the student nurse consists of the personal world, inner or intrapersonal world and the world of coexistence.
- v) The personal world of the student working in mental health care settings, is one in which she/he explores and adapts to live meaningfully.
- vi) The inner or intrapersonal world of the student is a world of becoming, endeavour and understanding. The student nurse must understand, trust and accept the self, which is a basic responsibility as a spiritual being.
- vii) The student's world of coexistence is a world of interpersonal relationships which is encountering and interaction with those of others.

- viii) In the external world the student's need for emotional support is a response to the organisational, sociocultural and psychological needs of students working in mental health care settings.
- ix) The student will assume responsibility (internal world) for meeting his/her own emotional support needs once the organisational, sociocultural and psychological needs are met.
- x) In order to support students emotionally, collaborative liaison between the HEI and mental health care setting which forms part of the external world is essential.

### **5.9 STRUCTURE OF THE MODEL**

Chinn and Kramer (2004) state, that the concepts must be given a structural form in order to identify relationships between them. Structural forms assist in shaping perceptions of reality. The structure of the model emerged from the relationships between the six main concepts - namely positive work environment, positive self-concept, academic and professional development, effective communication, informal and formal supportive intervention strategies and collaboration between the HEI and mental health care setting. The model depicted in figure 5.2 is divided into its different parts according to the main concepts, to assist in the meaning of the discussion and to explain the interaction between the concepts.

**AN EMOTIONAL SUPPORT MODEL FOR STUDENTS WORKING IN MENTAL HEALTH CARE SETTINGS**

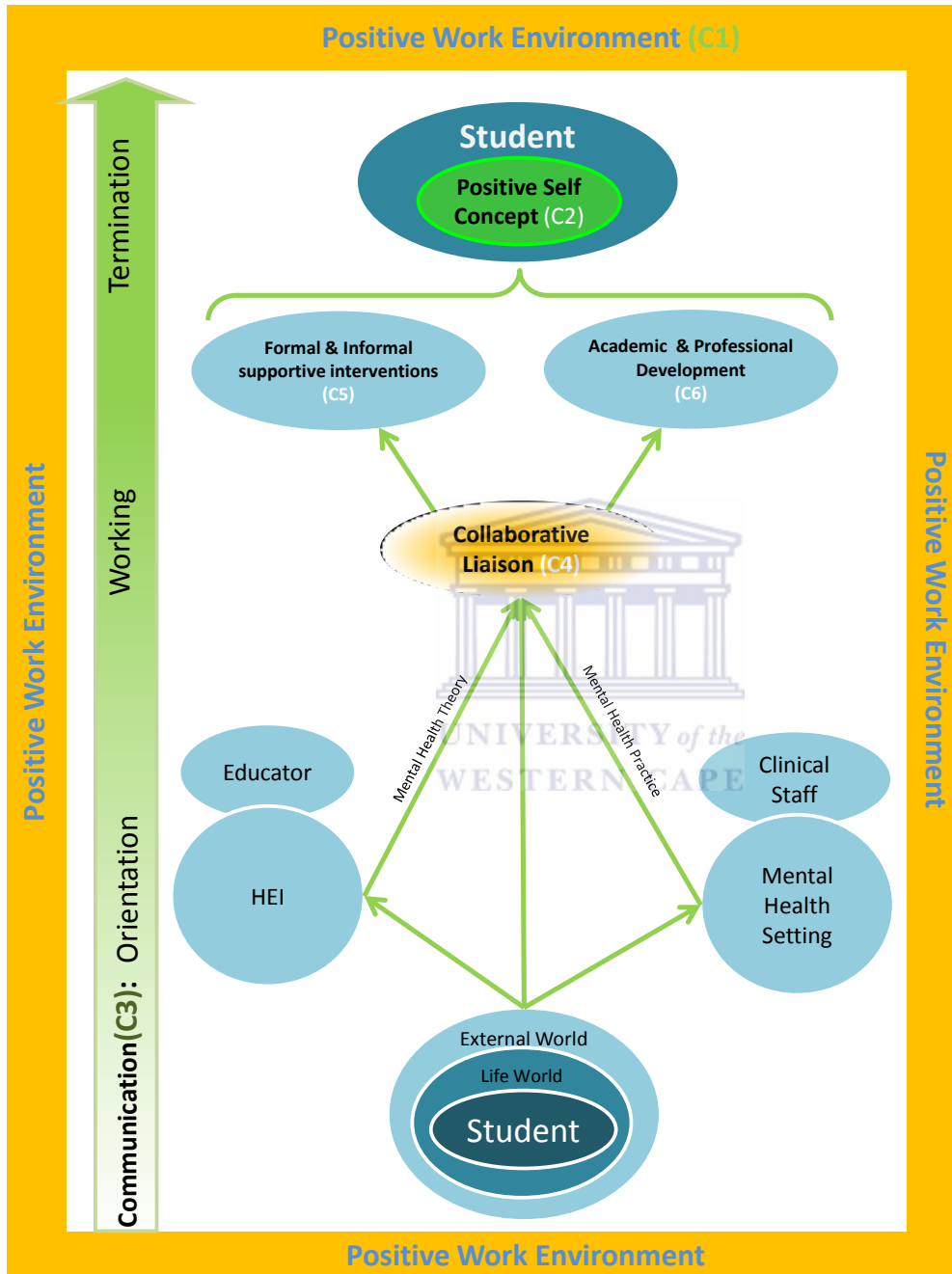


Figure 5.2 Model of emotional support of students working in mental health care settings

The main concepts are depicted by the letter C meaning 'concept', for example positive work environment is depicted as C1 and is hence concept 1. The numbering of the concepts such as concept 1, concept 2 and so on - are in no order of significance as the process of facilitating emotional support of students is iterative.

A positive work environment (C1) encapsulates the total student learning environment - namely the resources (internal and external), events, behaviours, individuals and processes.

Empirical evidence refers to those elements within a positive work environment, which would be deemed as being emotionally supportive for students working in mental health care settings. These include a positive staff attitude, cultural competency, role modelling and destigmatisation. A **positive staff attitude** may instil a **sense of belonging** in the students, making them feel that they are accepted and are part of the mental health care environment. Positive attitude refers to the affirming evaluations students make during their interaction with educators and clinical staff (Cunningham, 2011). The evaluations are perceived to be emotionally supportive. Positive attitude also refers to the affirming response of educators and clinical staff towards students, which make students feel welcomed and cared for in the mental health care environment. Sense of belonging is the students' perception that they are part of the team in the mental health care setting which is characterised by interaction with others, acceptance and mutual concern between self, educators and the clinical staff.

They may develop a sense of **trust** in the educators and clinical staff, and as a result articulate their distress which would lead to them feeling emotionally supported. The online Merriam Webster dictionary (<http://www.merriam-webster.co>) defines trust as the belief that someone is good, honest, reliable and effective; reliance on the character, ability, strength and truth of someone or something. Gamble and Gamble



(1998) assert that the concept trust is based on one's perception of an individual's character. This means that we judge someone as being of good character and integrity which implies the person possesses a basic honesty which permeates the relationship (<http://www.merriam-webster.com>).

A positive staff attitude may also increase student **self-confidence** and **self-awareness** resulting in students assuming responsibility for attaining their own emotional support needs (goal). Self-confidence is the confidence that the students have in their own abilities to perform tasks and to care for patients in the mental health care setting. In order for the student to feel emotionally supported when working in the mental health care setting, they need to feel self-confident.

Self-awareness is the process whereby the student examines personal feelings, actions and reactions with the goal of achieving authentic, open and personal communication (LaTorre, 2005; Vandemark, 2006). In this study students indicated the need to belong, which is important as it implies human concern and is essential for students to feel that they are being supported emotionally.

These personal characteristics of students are linked to the development of a positive self-concept (C2).

**Cultural competency** is a part of the positive work environment, given that students come from diverse sociocultural backgrounds. Cultural competency is the respect that the educator and clinical staff display towards the student as a unique human, emanating from a different sociocultural context than his/her own and displays a genuine interest in learning more about the transcultural diversity with the ultimate aim of realising the goal (Stuart, 2009).

The sociocultural background may have an influence on the students' beliefs regarding mental illness and also how they cope with the mental health care environment.

On a professional level, a positive work environment alludes to **role modelling** of professional behaviours by educators and clinical staff that students can emulate. Role models are nurses whose behaviour in the nursing profession is imitated by students (<http://www.merriam-webster.com>). The Oxford Dictionary (2007:2601) defines a role model as a person who is looked at by others in a particular role. Role models are nurses who display qualities, for example professionalism, that are worthy of emulation. Students may experience role modelling behaviour as being emotionally supportive when they can actively observe the professional behaviour of educators and clinical staff and aspire to be a part of the nursing profession.

The nature of the mental health care setting may lead to destigmatisation given the disease profile of the patient population and the stigma associated with working with mentally ill patients. According to the online Merriam Webster dictionary (<http://www.merriam-webster.com>) destigmatising refers to the 'act of removing associations or disgrace'. The act of removing the disgrace associated with being mentally ill or caring for patients with mental illness, may result in students feeling emotionally supported. **Destigmatising** of the mental health care environment may reduce fear and anxiety in students - which may be deemed to be emotionally supportive.

Effective communication (C3) is depicted as a green arrow from the student to the positive self-concept. This arrow signifies the interpersonal communication which takes place within the individual/environment transaction. According to Gamble & Gamble (1998) interpersonal communication is defined as a process of making personal contact i.e. building connections to establish a relationship with another individual/s in order to satisfy own social needs. Interpersonal communication is

important in building the students' personal identity, in other words- who they are in relation to others (Gamble & Gamble, 1998).

Within a collaborative liaison relationship, educators and clinical staff engage with students by means of communication to build the students self-concept.

This process takes place by means of an **orientation, working** and **termination** phase. The green colour which is initially lighter in colour becomes darker green depicting growth at the terminus phase in which the student, once the identified deficits have been addressed, has developed a positive self-concept. These phases will be discussed under the heading 5. Process description of the model.

In the communication process throughout the model, collaborative liaison (C4) is the energy which permeates through the students, educators, clinical staff, HEI, mental health care setting, supportive interventions, as well as academic and professional development which results in the students developing a positive self-concept. The construct, collaborative liaison, has been defined previously (see 5.4 iv) and emanates from the main concept 'collaboration'. An element linked to the collaboration between the HEI and clinical setting is **multidisciplinary team collaborate approach**. According to the online Merriam Webster dictionary (<http://www.merriam-webster.com>) multidisciplinary team refers to a group of people working together from a field of study. In this study, the multidisciplinary team refers to the psychologist and the nurses who students identified as being important individuals for providing supportive services such as, for example, counselling. These However people providing support to students is not limited to these individuals as support needs are diverse, which may be met through other individuals such as peers and family members to name but a few. These individuals work together through mutual sharing and understanding towards a common goal viz. to provide emotional support to students so that students will be able to assume

responsibility to meet their own emotional support needs. This suggests that facilitating emotional support for students working in mental health care settings is a shared responsibility, with individuals from diverse occupations and social responsibilities, who collaborate to provide emotional support to students.

Arrows diverge from collaborative liaison to formal and informal supportive intervention strategies (C5) as well as academic and professional development (C6).

Both C5 and C6 refer to student emotional support needs as identified by students, educators and clinical staff. The needs although initially categorised separately for the HEI and mental health care setting illustrated similarities hence the convergence.

Formal supportive intervention strategies (C5) included **psychological interventions**, which includes but is not limited to, **mentoring** and **counselling** as well as **structured programmes**. According to the online Merriam Webster dictionary (<http://www.merriam-webster.com>) psychological interventions are actions which are performed to bring about change in the students behaviour, emotional states or feelings. The actions undertaken to modify the emotional states in students will be discussed in 5.12 Guidelines for operationalization of the model. Informal supportive intervention strategies identified in this study include **social support**, **emotional self-care activities**, the **availability** and **accessibility** of educators and clinical staff. Social support is the support given to students by the peers, family, friends and community. Emotional self-care activities are activities which the students undertake to improve their mental health, prevent disease, limit illness, and restoring mental wellbeing. These activities are derived from the knowledge and skills from both professional and students own experience. Students may undertake them on their own behalf or in participative collaboration with professionals such a psychologists (World Health Organization, 1983). Informal supportive interventions

also include the need for the educators and clinical staff to be available and accessible when students are in distress or require their guidance or assistance.

Academic and professional development (C6) needs identified which are important for the emotional support of students include **academic development** which focuses on **preparedness of students** to work in mental health care settings. Student preparedness relates to **knowledge, skills, and attitudes** that students must have developed in order to render care to mentally ill patients. This implies that students need to be prepared which translates into a feeling of confidence in their own abilities to render mental health care.. **Professional development** refers to the **skills, knowledge and attitudes** of educators and clinical staff which need to be developed so that they can provide emotional support to students.

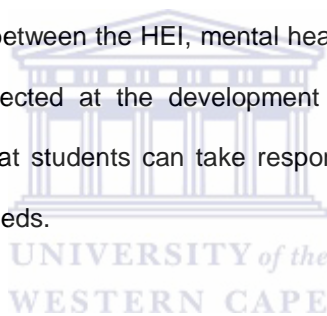
It is proposed that an emotional support model for students working in mental health care settings incorporating all the elements described above, through a process of collaborative liaison, culminate in the development of positive self-concept (C2) in the student.

#### **5.10 RELATION STATEMENTS OF THE MODEL**

The relation statements of the model were developed by means of identifying the relationship between the concepts and the six elements on the survey list.

- A positive work environment is attained through the collaborative liaison between the HEI, the mental health care setting and the student.
- Academic and professional development is the result of the collaborative liaison between the HEI, mental health care setting and the student towards developing a positive self-concept

- Formal and informal supportive intervention strategies are the consequence of collaborative liaison between the educators and the clinical staff, aimed at providing emotional support to students working in mental health care settings through an effective communication process.
- Collaborative liaison occurs between the HEI and the mental health care setting in an attempt to ascertain students' self-identified needs in order to facilitate emotional support for the student.
- The students' positive self-concept is the outcome of collaboration between the HEI, the mental health care setting and the student, which result in the provision of support to the student.
- Interpersonal communication between the HEI, mental health care setting and students result in actions directed at the development of a positive self-concept of the students so that students can take responsibility for meeting their own emotional support needs.



### **5.11 PROCESS DESCRIPTION OF THE MODEL**

The model illustrates that through the process of interpersonal communication - which occurs during the orientation, working and termination phases – students' emotional support needs may be met. It is envisaged that the students will assume responsibly for their own emotional support needs and display a positive self-concept. In the model, the arrows indicate this relationship.

#### 1) Orientation phase

Prior to engaging with the students, the educators and clinical staff's initial task in the process will be self-exploration. They need to explore their own attitude towards students from the HEI, their misconceptions and prejudices. They need to explore

their own insecurities, fears and behaviour through self-assessment. Educators and clinical staff will start collecting data about the students from the available information. This can occur via colleagues who may previously have worked with the students, the students' peers giving information about them or clinical placement lists which are obtainable from the administrative officer at the HEI. Planning for the first contact with the students occur during this phase. This occurs by means of familiarisation of the students' learning objectives and planning the activities and events that the students will attend when they arrive at the ward, in the mental health care setting.

Clinical staff meet the students in the mental health care setting. In collaboration with the educator responsible for student supervision in the mental health care setting, the clinical staff ascertain the student expectations and fears they may have about working in the mental health care setting. Collectively the students' learning objectives are reviewed with the aim of establishing how they will be achieved. The academic preparedness of the students to work in mental health care settings is explored. The student, educator and clinical staff establish a collaborative relationship. They then ascertain what the students' emotional support needs are. The focus during orientation is the students' emotional support needs; the educators and clinical staff are the facilitators during this process. Through the interpersonal process of communication, they listen to students which may portray understanding of the students' experience. Role expectations and responsibilities are clarified so that students know what to expect from the educators and clinical staff, as well as what is expected of them. In order to establish a trusting relationship, both educators and clinical staff ensure that they display a positive attitude towards the students. Collaboration between the HEI and clinical setting is formalised so that educators

and clinical staff work in a collaborative manner, to ensure that students experience the mental health care setting as emotionally supportive.

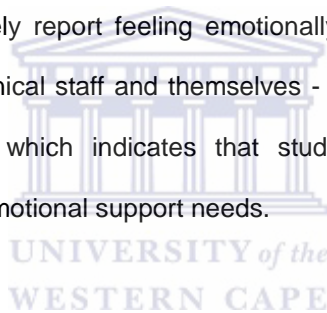
## 2) Working

The educators, clinical staff and students explore formal and informal supportive intervention strategies, with the view of ascertaining what interventions are applicable given the diverse needs of the student population. On an informal level, the use of social support in terms of family, friends and peers was encouraged. In this study, students discovered that they could depend on their peers for emotional support as they too were experiencing emotional dissonance deriving from working in the mental health care environment. A range of emotional self-care activities were identified by educators, clinical staff and students. Students were encouraged to engage with these supportive activities so that they could experience emotional support. These activities are aimed at giving students a sense of control, reduce anxiety and increase self-responsibility. The focus during the working phase is the promotion of emotional wellbeing. Students are encouraged to utilise problem-focused coping strategies, to cope with the mental health care environment. Students are urged to interact with the educators and clinical staff in the mental health care setting through activities which would create a sense of belonging, as well as increase self-confidence and self-awareness. Academic and professional development deficits such as lack of knowledge, skills and attitude in educators, clinical staff and students are identified and acknowledged. Students may indicate unpreparedness to work in the mental health care setting due to lack of clinical skills. Through a collaborative liaison approach, the relevant role players will intercede by addressing this deficiency by means of skills training.



### 3) Termination.

During the termination phase the students' experience of working in the mental health care setting is explored by the educators and clinical staff. They evaluate the students' self-concept by assessing their work experiences in the mental health care setting. The students' level of self-awareness and self-confidence are assessed to ascertain whether students are able to assume responsibility to meet their own emotional support needs. Educators and clinical staff examine student adaptive coping strategies in a peer group setting, in the hope of the students' peers learning healthy coping strategies. Within this setting, students may also be able to identify areas within their personal lives that require action which indicates a sense of self awareness. Students who subjectively report feeling emotionally supported by the collaborative efforts of educators, clinical staff and themselves - may be considered as having a positive self-concept which indicates that students may assume responsibility for meeting their own emotional support needs.



## **5.12 GUIDELINES FOR THE OPERATIONALIZATION OF THE MODEL IN PRACTICE**

Broad guidelines for operationalizing the emotional support model for students working in mental health care settings will be described within the context of the HEI and the mental health care setting. The guidelines will be discussed using the three phases of the communication process namely: 1) orientation 2) working, and 3) termination phase. Objectives and strategies to address the objectives will be mentioned.

### 5.12.1 Orientation phase

**GUIDELINE 1: Educators, clinical staff and students must create a positive work environment to ensure that students develop a positive self-concept.**

#### **Objective (i)**

- To establish a collaborative relationship between the HEI and the mental health care setting

#### **Strategy**

- A partnership agreement between the HEI and the mental health care setting stakeholders should be drawn up to define roles and responsibilities around student support. These should be explicitly stated;
- Policies and guidelines regarding student support must be developed in collaboration with the stakeholders from both HEI and the mental health care setting to ensure buy in from the mental health care setting;
- Establish a system of communication between the HEI and mental health care setting;
- Establish a feedback loop specifying time frames for addressing student matters between the various stakeholders;
- Attendance of educators and clinical staff to stakeholder meetings in both the HEI and the clinical setting, where student issues are discussed;
- Student emotional support needs must be addressed through collaborative efforts to prevent a negative self-concept.

### **Objective (ii)**

- To create a positive staff attitude

### **Strategy**

- Ensure that educators and clinical staff are present when students are placed in the mental health care settings to clarify any misconceptions;
- Ensure that clinical staff are aware of the student clinical learning objectives;
- Instruct the student administrator at the HEI to inform the staff at the mental health care setting about student placements within the time frame established by both parties.
- Identify staff who can act as role models for students;
- Establish a mentoring system for students where challenges are addressed promptly;
- Have regular contact with students to ascertain coping;
- Establish a counselling service for students;
- Have regular meetings with students to discuss frustrations in and out the mental health care setting;
- Appropriate referral pathways for students who are traumatised;
- Develop a standardised student support file in collaboration with the relevant stakeholders, for all the mental health facilities. The information in the file should give guidance on how to address aspects relating to the student such as, channels of communication, referrals systems for students presenting with emotional distress or behaviour problems.

### **Objective (iii)**

- To orientate students to the mental health care setting

### **Strategy**

- Invite clinical staff to give input in the development of an orientation programme for new students in the fourth year;
- Invite clinical staff to participate in the orientation programme;
- Students need to be taught how to identify stress triggers;
- Clear policies and guidelines for students who need supportive interventions. Process algorithms for the management of distressed students need to be developed and displayed in all the mental health facilities and included in the students' module guides of the B Nursing programme;
- Arrange for students to physically visit the mental health care setting to familiarise themselves with the setting;
- Orientation programmes must include the clinical staff's inputs to ensure that students are exposed to the clinical staff prior to clinical placement in the mental health care setting;
- Inform students of the expectations regarding the B Nursing programme with regards to both theory and practice requirements.

### **Objective (iv)**

- To raise awareness about existing supportive resources

### **Strategy**

- Make appointment for students, educators and clinical staff to visit the university support service centre;
- Disseminate brochures or refer students, clinical staff and educators to the university website on student support services and referrals;
- Explore the feasibility of students utilising the mental health staff support service

- Establish a multidisciplinary team approach for student support;
- Identify key individuals at the HEI and mental health care settings which need to be contacted first in the case of student distress.

### **5.12.2 Working phase**

**GUIDELINE 1: The provision of formal supportive intervention strategies in collaboration between the HEI and mental health care setting.**

#### **Objective (i)**

- To establish a preceptorship programme for student support in the mental health care setting

#### **Strategy**

- Discuss the feasibility of a preceptor programme for student support with the relevant HEI and clinical setting stakeholders
- Funding may be shared under the partnership agreement between the HEI and the mental health care setting
- In collaboration with the HEI and mental health care setting identify potential preceptors in the services;
- Ensure that the preceptors receive training on how to support students using a preceptorship model.

#### **Objective (ii)**

- The provision of an available and accessible on-site student support service which students can access whilst working in the mental health care setting.

### **Strategy**

- Explore the feasibility of a student support services at the mental health care setting;
- Recruitment and selection criteria of a support person to work at the centre must include nursing clinical expertise and knowledge about mental health nursing, qualities of empathy, being non-judgemental and listening skills.

### **GUIDELINE 2: The provision of informal supportive intervention strategies in collaboration between the HEI and mental health care setting.**

#### **Objective (i)**

- To encourage the use of social support and emotional self-care activities

#### **Strategy**

- Students should be encouraged to plan socialisation time;
- Encourage access and use of family, friends and peers to provide support;
- Encourage students to participate in leisure activities such as reading, sport and exercise;
- Encourage the use of reflective journaling to obtain catharsis when feeling emotionally drained;
- Offer guidance to students who attempt to balance work and life;
- Empower students on strategies which they may use to increase safety in the mental health care setting.

#### **Objective (ii)**

- To establish a peer support system for students

### Strategy

- Identify potential student leaders in the fourth year of the B Nursing programme. This may be done by perusal of the recipients of the Golden Key Awards at the HEI;
- Recruit students to offer peer support. Ensure that they receive basic counselling skills training;
- Establish a telephone tree to link a buddy system which students can access.

### Objective (iii)

- To establish a telecommunication system for student support

### Strategy

- Establish a 'Student Support Life Line' which students can access anonymously should they be distressed;
- Recruit volunteer counsellors to manage the telephones;
- Feasibility of funding the telecommunication system via a sharecall fee structure where both HEI and mental health care setting share the cost of the call.

**GUIDELINE 3: Academic and professional development of students, educators and clinical staff to ensure that students are prepared to work in mental health care settings and educators and clinical staff are competent to effect student support and promote a sense of emotional wellbeing in students.**

### Objective (i)

- To increase the students' knowledge, skills and attitude about mental health care to promote confidence in caring for mentally ill patients

### **Strategies**

- Encourage students to take responsibility for their own learning by means of engaging with mental ill patients, clinical staff and educators;
- Students need to articulate their uncertainties to both educators and clinical staff to ensure that they obtain the correct information and learn the appropriate skills for use in the mental health care setting;
- Make time in class for reflection and guidance on how to manage patient

### **Objective (ii)**

- To encourage the professional development of educators and clinical staff to supervise students in the mental health care settings

### **Strategies**

- Clinical staff are encouraged to attend courses on preceptorship at the HEI;
- Educators are encouraged to attend mental health skills courses to augment and update their education



### **5.12.3 Termination phase**

**GUIDELINE 1: Assessment of the student to establish whether a positive self-concept was developed through the application of the strategies implemented during the first two phases of the communication process.**

### **Objective (i)**

- To discuss future plans and possible solutions to challenges students may experience in the mental health care setting.
- To discuss maintaining emotional well-being

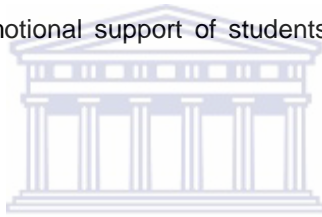


## **Strategy**

- Explore the students experience in the mental health care setting and how they may have dealt with the challenges;
- Assess the students resources and social support systems such as friends, family, peers and significant others to establish coping in the future.
- Assess how students view the relationship which has developed between themselves, the educators and clinical staff.

## **5.13 EVALUATION OF THE MODEL**

A guide for the critical reflection of theory has been taken from Chinn & Kramer (2004) to evaluate the model for emotional support of students working in mental health care settings.



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### **5.13.1 Clarity**

How clear is this model? Addressing this question means that the researcher should consider semantic clarity, consistency and structural clarity. Clarity also asks if the model brings new knowledge. The concepts and main concepts have been defined for applicability to the context. The structural description of the model is consistent with the description of the model.

### **5.13.2 Simplicity**

The model is simple because it only has six main concepts with identified relationships.

### **5.13.3 Generality**

The six major concepts are relevant for the discipline, mental health and can also be applicable to general nursing. The phases of the interpersonal communication process namely orientation, working and termination, are applicable to psychology, social work and occupational therapy. They can be applied in other settings in nursing such as palliative care which may also be a stressful working environment.

### **5.13.4 Accessibility**

The goal of this model is to develop the self-concept of student nurses so that their experience in the mental health care setting is deemed to be emotionally supportive. It is envisaged that students will assume the shared responsibility together with the educators and clinical staff for meeting their emotional support needs.

### **5.13.5 Importance**

The model is important because it provides both the HEI and mental health care setting with practical guidelines on how to support nursing students who work in a challenging context.

## **5.14 SUMMARY**

In this chapter the model of emotional support for students working in mental health care settings was developed using the theory generating process of concept development, model development, model description and development of guidelines to operationalize the model.

Chapter six focuses on the conclusion, recommendations and limitations of the study.

## CHAPTER 6

### CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

#### 6.1 INTRODUCTION

A description of the structure and the process of a model of emotional support were provided in chapter five. Guidelines for the operationalization of the model and a description of the critical reflection criteria for the evaluation of the model were also provided in chapter five. The focus of the final chapter is the summary, conclusions, limitations and recommendations for this study.

#### 6.2 SUMMARY AND CONCLUSIONS

The purpose of this research was to obtain information regarding the experiences of students working in mental health care settings from students, educators and clinical staff. The perceived support needs were also ascertained. The information obtained was used to develop an emotional support model for students. This model would assist both the HEI and clinical setting in providing emotional support relevant to the support needs as identified by students, educators and clinical staff. The objectives to attain the aim of the study were:

- To explore students' emotional challenges when working in mental health care settings.
- To explore students' emotional support needs when working in a mental health care setting.

- To explore how educators and clinical staff perceive students' coping in the mental health care setting, as a means of ascertaining their views on the students' emotional challenges in the mental health care
- To describe the strategies which education and clinical staff use to support students working in mental health care settings
- To develop an emotional support model for students working in mental health care settings - based on students' self-identified emotional needs, the students' emotional needs as identified by the education and clinical staff, and the existing strategies of student support.

A theory-generating design based on qualitative, explorative and descriptive research was used by the researcher to achieve the above-mentioned aim and objectives of the study. The design comprised of four steps, namely concept development, model development, model description and a description of the guidelines for operationalization of the model. A description of the critical reflection(s) to evaluate the model was also done.

Step one was the identification, description and the classification of the main concepts of the study. Six main concepts emerged from the concluding statements from the themes.

Step two of the research design focused on the development of an emotional support model.

Step three of the research design focused on the description of the model that was developed to assist HEI's and mental health care settings in providing emotional support for students working in the mental health care settings, with the aim of students eventually accepting responsibility to meet their own support needs. A visual representation of the structure of an emotional support model was given and

described. The process of the model was also described using the phases in an interpersonal communication process, namely orientation phase, working phase and termination phase.

Step four was the last step and provided guidelines for the implementation of the emotional support model and also a critical reflection of the model in terms of the five criteria for model development according to Chinn & Kramer, (2004) - namely clarity, simplicity, generality, accessibility and importance, and significance.

It can therefore be concluded that the aim and the objectives for this research has been achieved, as the researcher succeeded in:

- collecting the appropriate data from the participant groups that assisted her in identifying main concepts for the intended model;
- defining and classifying the main concepts;
- describing relation statements;
- developing and describing an emotional support model which would assist the HEI and the mental health care setting, to facilitate the emotional support of students relevant to their emotional support needs;
- describing the guidelines which were necessary to operationalize the implementation of the model.

In conclusion, the purpose of this research has been achieved because the researcher succeeded in developing an emotional support model for students working in mental health care settings. The model is clear, simple, understandable and important for use in both HEI and mental health care settings, in the provision of emotional support for students working in mental health care settings.

### **6.3 LIMITATIONS**

The following limitations were experienced:

- Only 10 Black male students (in three out of the six focus group interviews) participated in the study, with the majority (30) being female - which is not uncommon in nursing as it is a female-dominated profession. The researcher was of the opinion that although they volunteered to participate in the study their responses were guarded, and attributed this to being interviewed by a female researcher. The researcher, however, attempted to address this perceived limitation after the first focus group interview by recruiting a black male to interview the students, whilst the researcher adopted the co-researcher role. The males were then more vocal and interacted more easily in the following two focus group interviews.
- The study and model was conducted and developed using only participants from the University of the Western Cape thus cannot be generalised to other students.
- The model was not reviewed by the study participants to confirm if it represented their support needs.

### **6.4 RECOMMENDATIONS FOR NURSING PRACTICE AND EDUCATION, AND RESEARCH**

Recommendations are made for nursing practice and education, and research.

#### **6.4.1 Recommendations for nursing practice and education**

- There must be a collaborative approach between the HEI and the mental health care setting, to facilitate the emotional support of students working in mental health care settings. The emotional support model must be presented

at HEI/clinical meetings. These meetings are attended by representatives from the HEI and key individuals in the mental health care settings, who are responsible for decision-making about student matters such as student placements and identifying learning opportunities. This is to obtain buy-in from the stakeholders in the Provincial Administration of the Western Cape.

- Preceptors should be employed in the clinical areas that have a close working relationship with educators to supervise students, and offer them guidance and support.
- Commitment from both HEI and the mental health care setting to establish communication forums, such as monthly clinical meetings. Educators and clinical staff can use this forum to communicate needs, challenges, attend to and discuss student matters.
- The identification of clinical staff who are passionate about teaching students and through collaboration between the HEI and mental health care setting formalise their roles and responsibilities regarding teaching, learning and support of students. This will ensure that student wellbeing is not viewed as an additional task but rather as a part of the daily responsibilities of certain clinical staff.
- The clinical orientation programme, for students to mental health care settings, must be developed through collaboration between the clinical student coordinators of both HEI and mental health care setting.
- Clear policies and guidelines, for referral of students to support services within the HEI or clinical setting, need to be developed in conjunction with both HEI and clinical setting stakeholders. The information must be disseminated regularly at the monthly clinical meetings, to ensure that both clinical staff and educators are familiar with the referral path for vulnerable students.

- A student management system must be developed through collaborative efforts by the relevant HEI and clinical stakeholders, to ensure that student absenteeism and maladaptive behaviour are recorded and addressed promptly by the HEI. Students must be interviewed to ascertain the reason for their maladaptive behaviour or absenteeism. Negative issues which may affect student wellbeing need to be addressed by key stakeholders (HEI and clinical setting) promptly.
- The model can be used by the HEI student support services, to augment their current practices of offering general support to the entire HEI student body. Students studying a speciality discipline such as psychiatric nursing/ mental health nursing have specific needs which should be catered for. This model needs to be presented at the stakeholders meetings within the HEI, to propose emotional support strategies such as peer support programmes to enable student coping in mental health care settings.
- Definite support structures should be identified in the mental health clinical setting for student referrals.

#### 6.4.2 Recommendations for nursing research

- The emotional support model should be implemented within the HEI, and the effectiveness thereof be evaluated and refined through post-doctoral research;
- The application of the emotional support model in other challenging environments can be further researched;
- The emotional support model could also be implanted and tested in other South African nursing schools;
- Research topics identified include:
  - Concept analysis of the term **emotional support** in mental health nursing



- Student nurses' perception of professionalism when dealing with mentally ill patients who have a similar personal history as themselves
- Exploring the extent of perceived, as opposed to clinically diagnosed, mental illness in student nurses working in mental health care settings.
- Exploring the use of "identification" as a defence mechanism in student nurses working in mental health care settings.
- A quantitative study to measure student stress, anxiety and depression among student nurses working in mental health care settings and also from other diverse student populations.
- The design of the implementation of the model to determine if the model does decrease student stress.

## **6.5 SUMMARY**

This final chapter has provided an overview of the research process, which reflected on the purpose of the research and the objectives being achieved. One limitation of the study was mentioned. Recommendations for a collaborative approach to student support in mental health care settings, aimed at practice and education were listed. Recommendations were made for potential research topics which were considered suitable for research.

In conclusion, the study has shown that the mental health care environment is an emotionally stressful place for inexperienced students to work in. It is the researcher's belief that students can and should be emotionally supported in this stressful environment. The aim of supporting students is to ensure that once their emotional support needs are met, they will become self-reliant and assume responsibility for meeting their own support needs. However, in order to achieve this outcome, collaboration between the HEI and mental health care setting is important.

Initially a top down approach to facilitate the collaboration may be necessary. Once buy-in is obtained from the key individuals who have decision-making powers within the mental health care environment, change management becomes a bottom-up approach which is essential for the implementation of the emotional support model.



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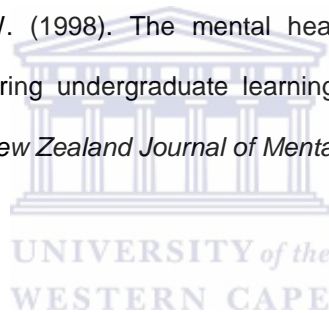


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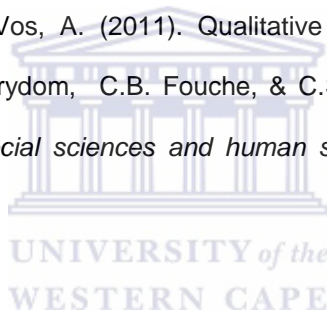
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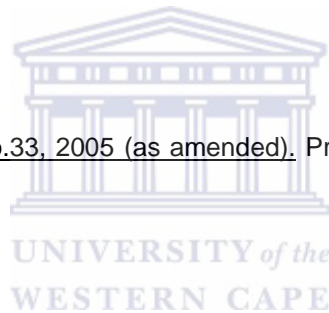
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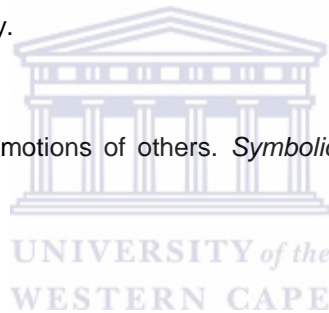
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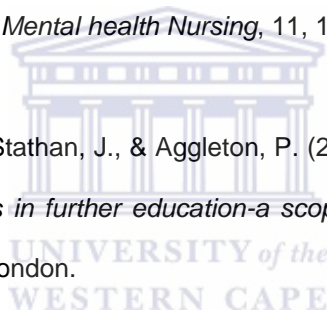
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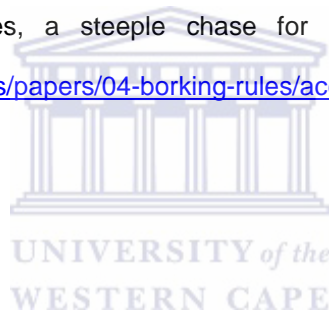
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OFFICE OF THE DEAN  
DEPARTMENT OF RESEARCH DEVELOPMENT

04 October 2011

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:  
Ms PD Martin (School of Nursing)

Research Project:

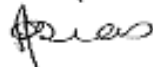
The development of a model for emotional support  
for under-graduate nursing students working in  
mental health settings.

Registration no:

11/8/12



UNIVERSITY of the  
WESTERN CAPE



*Ms Patricia Jasias*  
Research Ethics Committee Officer  
University of the Western Cape





## UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwe.ac.za

10 October 2011

Dear Prof Christie

**Permission to conduct research using UWC staff and 4<sup>th</sup> year nursing students as participants**

I hereby request permission to use the staff at the School of Nursing and the 4<sup>th</sup> year nursing students as participants in the following research project:

The development of a model for emotional support of undergraduate nursing students working in mental health settings.

The project has been approved by the Senate research Committee of the University of the Western Cape.

Registration no: 11/8/12

Yours sincerely,

Handwritten signature of Ms PD Martin.

Ms PD Martin



UNIVERSITY of the  
WESTERN CAPE



*I hereby grant permission to conduct this research on UWC's campuses.*

*Renja Christie  
Dean of Research  
14 October 2011.*

**From:** "Carol Dean" <cdean@pgwc.gov.za>  
**To:** "Penelope Martin" <pmartin@uwc.ac.za>  
**CC:** <Estellemalgas@pgwc.gov.za>, "Magda Karelse" <Mkarelse@pgwc.gov.za>  
**Date:** 2012/04/12 02:50 PM  
**Subject:** Fwd: Re: Permission to conduct research

Apologies, you have permission, will ask relevant parties to send off letter of support. Regards, Carol.

>>> "Penelope Martin" <pmartin@uwc.ac.za> 12/04/2012 14:47 >>>

Dear Carol

I was at Valkenberg this afternoon to inquire if you received official permission as i would like to complete data collection. I spoke to Desiree. She promised to discuss this with you. Can you please let me know how far is this process. I need the official letter when i complete the dissertation (in October) so an email approval will suffice for me to collect the data.

Kind regards

penny

>>> "Carol Dean" <cdean@pgwc.gov.za> 2012/02/03 11:19 AM >>>

Dear Penny

Magda Karelse is supportive of your research, we sent the request to HEAD OFFICE and will get official permission from them, they are normally supportive and I have asked them to speed up the process. Regards, Carol

>>> "Penelope Martin" <pmartin@uwc.ac.za> 16/01/2012 14:43 >>>

Dear Carol

Attached is documentation as requested.

Regards

Penny

>>> "Carol Dean" <cdean@pgwc.gov.za> 2012/01/12 12:47 PM >>>

Dear Penny

My system has been archived and your proposal was sent to Nursing, the HOD is on leave, please resend. Sorry about this. Regards, Carol.

Carol Dean

Chief Executive Officer

Valkenberg Hospital

Tel: (021) 440 3160

Fax: (021) 447 6041

Mobile: 084 496 8440

Email: cdean@pgwc.gov.za

>>> "Penelope Martin" <pmartin@uwc.ac.za> 12/01/2012 09:26 >>>

Dear Carol

I would like to inquire about the status of my permission to conduct research at Valkenberg. I would like to complete the interviews at the end of this month if I am granted permission.

Regards

Penny

>>> "Carol Dean" <cdean@pgwc.gov.za> 2011/11/28 02:27 PM >>>

Dear Penny, thank you for the invitation, we have sent it to the HOD: Nursing and will keep you informed of the outcome. Best wishes with your study. Regards, Carol

>>> "Penelope Martin" <pmartin@uwc.ac.za> 11/11/2011 08:40 >>>

Dear Mrs Dean

My name is Penny Martin. I am a lecturer in psychiatric nursing science at UWC. I would like to request permission to invite 2 registered nurses at Valkenburg hospital to participate in my study which focuses on support for student nurses working in mental health care settings. Participation will include an in depth interview of 30-60 minutes and a follow up interview (30 minutes) to verify the transcribed data.

Find attached the research proposal, ethics clearance and an information sheet. If I need to submit more information please let me know.

Kind regards

Penny Martin



**From:** "Nashareen Morris" <Nmorris@pgwc.gov.za>  
**To:** "Penelope Martin" <pmartin@uwc.ac.za>  
**CC:** "Joy Wheeler" <Jwheeler@pgwc.gov.za>, "Reneé Fisher" <Rfisher@pgwc.gov.za>  
**Date:** 2011/10/31 02:25 PM  
**Subject:** Re: Permission to conduct research

Dear Ms Martin,

I am pleased to announce that permission has been granted. I am including Mrs Fisher, our HOD of Nursing into my response so that you can liaise with her directly wrt the process.

Kind regards,  
Dr N.Morris

>>> "Penelope Martin" <pmartin@uwc.ac.za> 10/18/2011 3:46 PM >>>

Dear Dr Morris

My name is Penny Martin. I am a lecturer in psychiatric nursing science at UWC. I would like to request permission to invite 2 registered nurses at Alexandra hospital to participate in my study which focuses on support for student nurses working in mental health care settings. Participation will include an in depth interview of 30-60 minutes and a follow up interview (30 minutes) to verify the transcribed data.

Find attached the research proposal, information sheet and ethics clearance. If I need to submit more information please let me know.

Kind regards  
Penny Martin





Lentegeur Hospital

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10 November 2011

**Lentegeur Hospital Research Ethics Committee**

Lentegeur Hospital  
Highlands Drive  
Mitchells Plain  
7785

To whom it may concern

Re: Research Project - Development of a model for emotional support of undergraduate nursing students working in Mental Health settings

**Principal Investigator – Ms Penelope Martin**

This serves to confirm that the above research project has been granted ethical approval by the hospital Research Ethics Committee.



Yours Faithfully

A handwritten signature in black ink, appearing to be "P Smith".

Dr P Smith  
Chair – Research Ethics Committee  
Lentegeur Hospital

Highlands Drive, Mitchells Plain, 7785  
tel: +27 21 370 1111 fax: +27 21 371 7359

Private Bag X4  
Mitchells Plain, 7785



Enquiries : Mr J P M Visser  
Reference : 24/1

Penelope Martin  
University of the Western Cape  
Private Bag X17  
Bellville  
7535

Dear Madam


**RESEARCH : THE DEVELOPMENT OF A MODEL FOR EMOTIONAL SUPPORT  
OF UNDERGRADUATE NURSING STUDENTS WORKING IN MENTAL HEALTH SETTINGS**

This is to confirm that permission has been granted to conduct the research.

Please contact Mr Visser; Tel 021 940 8928.



Thank you

  
.....  
**MR C BARNARDO**  
**CHIEF EXECUTIVE OFFICER**

Date : *2011/10/28*.....

Stikland Hospital, De La Haye Rd, Bellville 7530  
Private Bag X 13, Bellville 7535  
tel: +27 940 4403 fax: +27 940 4559

[cbarnard@pgwc.gov.za](mailto:cbarnard@pgwc.gov.za)





**STRATEGY & HEALTH SUPPORT**

healthres@pgwc.gov.za  
tel: +27 21 483 9907; fax: +27 21 483 9895  
1st Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001  
[www.capegateway.gov.za](http://www.capegateway.gov.za)

REFERENCE: RP 135/2011  
ENQUIRIES: Dr V Applah-Baiden

**UNIVERSITY OF THE WESTERN CAPE**  
**PRIVATE BAG X17**  
**BELLVILLE**  
**7535**

For attention: Ms PD Martin

**Re: Development of a model for emotional support of undergraduate nursing students working in mental health settings**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries.

**Dr Abdurahman CHC**

**Ms BV Julius**

**(021) 638 3319**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za)).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

  
**DR T NALEDI**  
**DIRECTOR HEALTH IMPACT ASSESSMENT**  
DATE: 12/02/2012

CC

**DR J CLAASSEN**

**DIRECTOR: KLIPFONTEIN/MITCHELLS PLAIN**



05 December 2013

Dear Madam/Sir

This is to certify that Archibald J. Groener, Language Practitioner in the employment of the Parliament of the Republic of South Africa, edited the research report – ***The Development of a Model for Emotional Support for Under-graduate Nursing Students working in Mental Health settings*** by Ms Penelope Dawnette Martin. This report, as Doctoral Thesis, is being submitted in fulfillment of the requirements for the degree of Doctor of Philosophy.

The onus is, however, on the author to make the changes suggested and to attend to the queries.

Please direct any queries regarding the editing of this article to me.



Yours sincerely

A.J. Groener  
Language Practitioner  
Parliament of the RSA  
[agroener@parliament.gov.za](mailto:agroener@parliament.gov.za)  
021 4032777 (w)  
082 7726409 (m)



## UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwc.ac.za

### INFORMATION SHEET

**Project Title: The development of a model for emotional support of undergraduate nursing students working in mental health care settings**

#### **What is this study about?**

This is a research project being conducted by PENELOPE MARTIN at the University of the Western Cape. We are inviting you to participate in this research project because you are student, educator or clinical specialist in the field of mental health. The purpose of this research project is to develop a model of emotional support based on identified student needs in mental health care settings. The model will be developed using data from focus group and in-depth interviews.

#### **What will I be asked to do if I agree to participate?**

You will be asked to:

- participate in a minimum of two **focus group discussion (student participants)** to explore your experiences of working in mental health care. You are requested to provide specific situations, experiences, or examples (present or past) which you remember at this moment. Try to be as clear and specific as possible without being very general, e.g. *"the experience was good"*. The focus group discussion will be tape recorded after informed consent was obtained and should not take longer than 45-60 minutes.
- participate in a **semi-structured interview (educators and clinical staff)** to explore how you experience student coping and to assist in the development of a model for emotional support for student nurses working in mental health care settings. The duration of the interviews should be no longer than 30-60 minutes.

**Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality all the information will not be permissible to anyone outside the research team and we will never mention your name in our records. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

**What are the risks of this research?**

There are no envisaged potential risks identified. If any psychological/emotional distress as a result of this study are experienced, I will make sure that you are referred an appropriate empathetic specialist who you can talk to.

**What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the investigator learn more about the experiences of students working in mental health care settings. The information will be used in the formulation of a model and practice guidelines for emotional support for students working in mental health care settings. We hope that, in the future, other students might benefit from this study through implementation of the model to support them emotionally in mental health care settings.

**Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify.

**Is any assistance available if I am negatively affected by participating in this study?**

You will be referred for counselling if you experience any psychological/emotional distress as a result of this study.

**What if I have questions?**

This research is being conducted by Penelope Martin at the University of the Western Cape. If you have any questions about the research study itself, please contact

Ms P Martin at: 021 959 9345; pmartin@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Head of Postgraduate Studies: Professor O Adejumo

Director of the School of Nursing: Professor T Khanyile

Faculty of Community and Health Sciences,

University of the Western Cape.

P/Bag X17

Bellville

7535

021-959 2271

Supervisor: Prof F Daniels

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



**UNIVERSITY OF THE WESTERN CAPE**  
**INFORMATION SHEET TEMPLATE**  
**ADDITIONAL GUIDANCE FOR SPECIFIC ISSUES**

**Informed Consent**

Informed consent is a process, not just a form. Information must be presented to enable persons to voluntarily decide whether or not to participate as a research subject. Therefore, informed consent language and its documentation must be written in language that is understandable to the people being asked to participate.

**Research Involving Minors**

For research involving individuals under the age of 18, include a Parental Permission Form to ask parents for consent to the participation of their child and an Assent Form to ask the minors if they agree to participate in the research, depending on whether the children are capable of assenting. The Parental Permission form should contain all of the elements of the sample consent form. However, the parental permission form should be written in language appropriate for parents granting permission for their child's involvement rather than as though they themselves will be participating (e.g. we are inviting your child to participate the risks to your child's participation include). When determining whether the children are capable of assenting, take into account the ages, maturity, and psychological state of the children involved. Assent forms should be written in age-appropriate language.

**Research Involving Individuals with Impaired Decision-making Capacity**

Using the Informed Consent Form Template, prepare a consent form to ask the research subject's authorized representative for consent to the participation of the research subject. Prepare an assent form to ask the research subjects if they agree to participate in the research, depending on whether the subjects are capable of assenting.

When determining whether the subjects are capable of assenting, take into account the decision-making capacity of the research subjects.

**SUGGESTED WORDING**

Instructions: You should cut and paste these paragraphs, where applicable, into the appropriate area of the Informed Consent Form. However, the suggested wording below should be modified appropriately for the specifics of your study.

**Audio taping/Videotaping/Photographs/Digital Recordings**

**[Include the following information in the What about confidentiality? section]**

This research project involves making [*audiotapes/videotapes/photographs*] of you. **[Then explain why the tapes/photos are being made, who will have access to them, where they will be stored, and when (or if) they will be destroyed]**

\_\_\_ I agree to be [videotaped/audiotaped/photographed] during my participation in this study.

\_\_\_ I do not agree to be [videotaped/audiotaped/photographed] during my participation in this study.

**Research Projects Involving Data Collection in a Classroom**

**[Include the following information in the Do I have to be in this research? Can I stop participating at any time? Section]**

Participation in the research is not a course requirement.

**Research Projects Involving Prisoners**

**[Include the following information in the Do I have to be in this research? Can I stop participating at any time? Section]**

Your decision to participate or not participate in this research project will not affect or influence the length of your sentence, your parole, or any other aspect of your incarceration. Also, if you decide to participate and then leave the study before it is over, that will not affect or influence the length of your sentence, your parole, or any other aspect of your incarceration.





# UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

*Tel: +27 21-9599345, Fax: 27 21-9592679*

**E-mail: pmartin@uwc.ac.za**

## CONSENT FORM

**Project Title: The development of a model for emotional support of undergraduate nursing students working in mental health care settings**

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

- **Participant's name:** .....
- **Participant's signature:** .....
- **Witness's name:** .....
- **Witness's signature:** .....
- **Date:** .....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

**Researcher: Penelope Martin.**  
**University of the Western Cape**  
**Private Bag X17, Bellville 7535**  
**Telephone: (021) 959- 9345/2271**  
**Cell: 0725742360**  
**Fax: (021) 959- 2679**  
Email: pmartin@uwc.ac.za



## UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: [pmartin@uwc.ac.za](mailto:pmartin@uwc.ac.za)

### FOCUS GROUP CONFIDENTIALITY BINDING FORM

**Project Title:** The development of a model for emotional support of undergraduate nursing students working in mental health care settings

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

- Participant's name: .....
- Participant's signature: .....
- Witness's name: .....
- Witness's signature: .....
- Date: .....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

**Researcher: Penelope Martin.**  
**University of the Western Cape**  
**Private Bag X17, Bellville 7535**  
**Telephone: (021) 959- 9345/2271**  
**Cell: 0725742360**  
**Fax: (021) 959- 2679**  
Email: [pmartin@uwc.ac.za](mailto:pmartin@uwc.ac.za)

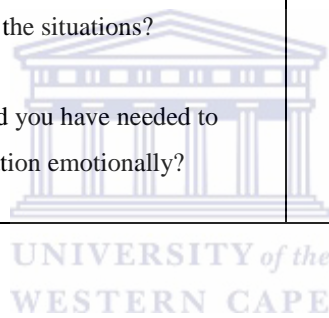


**INTERVIEW GUIDE: STUDENTS**

**These questions are the themes but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.**

**Students**

Questions	Probes
<ol style="list-style-type: none"> <li>1. Tell me about your experience of working in the mental health care settings? (probe for specifics)</li> <li>2. Tell me about your feelings in these specific incidents?</li> <li>3. How were you able to cope with the situations?</li> <li>4. What support do you think would you have needed to enable you to cope with the situation emotionally?</li> </ol>	



**INTERVIEW GUIDE: EDUCATORS**

**These questions are the themes but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.**

Questions	Probes
<ol style="list-style-type: none"> <li>1. What are the issues that you are aware of that students have to cope with emotionally?</li> <li>2. What are the strategies that you use to assist them to cope?</li> <li>3. What existing support services are in place to support students emotionally?</li> <li>4. What would you suggest that the SoN put in place to support students who work in mental health care settings?</li> <li>5. What would you suggest that the clinical services put in place to support students in this emotionally challenging environment?</li> </ol>	<p>Direct into the emotional effects</p>

### INTERVIEW GUIDE: CLINICAL STAFF

**These questions are the themes but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.**

Questions	Probes
<ol style="list-style-type: none"> <li>1. What are the issues that you are aware of that students have to cope with emotionally?</li> <li>2. What are the strategies that you use to assist them to cope?</li> <li>3. What existing support services are in place to support students emotionally?</li> <li>4. What would you suggest that the clinical services put in place to support students in this emotionally challenging environment?</li> <li>5. What would you suggest that the SoN put in place to support students who work in mental health care settings?</li> </ol>	

**EXAMPLE OF A TRANSCRIPT- FOCUS GROUP INTERVIEW WITH STUDENTS**

Archival #: FGI VBH01
Site: Valkenberg Hospital
Data collector: P Martin/W Archilles
Date of data collection: 16 November 2011
Transcriber: G Kassiem

INTERVIEWER (Male): Good afternoon, ladies and gentlemen. Now you have had this experience of psychiatry working in different situations, so I wonder what was your experience working in these situations emotionally. How did it affect you emotionally?

PARTICIPANT 2: For me, I had my ups and downs emotionally. Sometimes it took me days and sometimes I was not so upset. Cause I remember my experience I was working in [m] ... I don't know, community or psychiatry was a bit different. That's what I noticed. Because the community is the people that you live with. The community, they just come there to assist me. The [NEC] to assist me and go back. Now for the first time I have to get their whole history. What actually happened, was that... now to do the NEC is to listen to the story that they tell. And sometimes it would be so sad. One ... that was about to use your intelligence. He was about my age. He was still young. He is twenty one and I am twenty two. He finished his matric. He was very clever, but when he went to initiation then that thing started to come back. Now his mother believed that he was bewitched or something. And the way he was considered, you could see he was psychotic and he lost like he was not in touch with the reality. Now getting to hear the mother say he must go to... he must become a doctor, now he is in this state. I was in tears when she told her story. So for me I would end up crying as well. And the Sister who was our supervisor she was the Sister there: I don't think you're strong for psychiatry because you take this story... you personalised it, you should be able to draw a line don't take it too personal. Don't take it too personally. I cried all the time and then would go out and take a break again. She said I must think about it and leave it, because... So it was emotionally challenging.

INTERVIEWER: May I just enquire what do you mean when you say that your experience was emotionally up and down. What do you mean by that?

PARTICIPANT 2: I would experience emotions like happy when I see fun stuff or the patient is improving or maybe the patient was very psychotic, but on the third or fifth visit you see them actually improving and that he is starting to look for a job or he is doing something constructive. And you actually see that the medication is helping and you think, you know, that there is a positive and light at the end of the tunnel. So you feel so happy; almost like hugging the patient good luck and hope that all goes well.

PARTICIPANT 9: I also had experiences when starting this year with psych training from this year in Alexander hospital. When they place the students in the ward. You don't have a Sister. We only have one staff and nobody telling us what you are going to do or what you should do. And sometimes you see the stuff that... I can't get rid of the feelings. And I can't recall my problems at time. I can't sleep over and over. I even can't go to school. And I don't know what is happening to me.

And at that time you didn't realise that you have a problem and my husband realised that I had a problem, why didn't I tell him. I just suddenly blew up. I overslept for two days and I looked like ... I don't eat. I don't feel hungry. I sometimes like in a conversation, I try to listen and somehow I'm just like a block. Some people were like wake you up and you're working all the time. You're just like a block and then my husband told me, you stop going to school. And you stop working. I just stayed at home for six days just sleeping, go out some times and play golf. But after that time I saw someone cry and I refused to talk to her. ... so I ... don't want to be in that sad ... even now I'm working in... I tell you my story. I can't work I just go to other... drinking coffee otherwise I can't. I feel that I don't feel that ... psychiatry.

INTERVIEWER (Male): I wonder when you talk about these feelings ... What kind of feelings is it?

PARTICIPANT 9: First time you feel some pain.

PARTICIPANT 9: Like you can't ... how people can do that and you also scared. How come ... It is scary. You tell the story to Sister then you try something. So you just like keep quiet. And after that, you report that... you feel so scary afterwards. And

after that you see the patients still do that. sometimes even like some ... whether it is in my hands and you can smell... [inaudible] in my hands.

INTERVIEWER (Female): Just to get clarity. If this that you are describing now is it only now in the fourth year or is it something that have been coming on...?

PARTICIPANT 9: It started in fourth year. Even second year, I worked in trauma. I see a lot of dead people. I don't have any feelings. I'm just happy .. go and quickly do that and even patients dying in front of me I don't feel scared. I don't know why their feelings or their behaviour can irritate me. I really don't know.

PARTICIPANT 3: As Ms you identify... I remember sitting with patients telling me their story. And you think, I've been through that. and you kind of try and uphold it, not going through things, but here you have somebody going through the same things that you do. But you must keep a straight face and say, you know, you understand, because you must be professional because you can't be a human being with emotions in front of your patient.

And then going home and just cracking because you could identify so much and you could feel so much with that patient. And for me, this whole year was an emotional year. Studying was just ... psychiatry was difficult and a lot of ... I have identified with other students as well, a lot of personal things have happened with all of us, either family crises or relationship stuff. It has been as if everything has come at once and it really, I could identify with the lecturer on going out so much because it was like me. It was where I was at that point.

INTERVIEWER (Male): And what would you say – what ... in terms of emotions, what types of emotions have you been experiencing?

PARTICIPANT 3: Probably, I don't know - anger.

PARTICIPANT 3: I don't know. depressive states. I could almost diagnose every psychiatric condition you get partly in myself. Yes, it is everything. I couldn't always identify what I was feeling. It was sometimes a confusion and a mix of ...

INTERVIEWER (Female): did you have any good experiences?

PARTICIPANT 3: Hmm. There probably was, but they don't stand out.

PARTICIPANT 5: For me, doing psychiatry this year, was more like an eye-opener for me, because having to learn about the psychiatric diseases and conditions, because where I'm coming from it is a bit different, because okay, I'm coming to the Eastern Cape, rural area that if you see an old lady who is disorientated who talks about people who died a long time ago, the people will say that person is bewitched and that person gets killed, you know.

So for me, it was more like having to understand that this person maybe suffering from dementia and stuff like that. So for me, it was more like an eye-opener. Even with schizophrenias and stuff, especially one sick person that Participant , she talked about a lady that had a son who was brilliant and went to the initiation school and came back a psychotic. Mostly that is caused by dagga, because mostly dagga is used there. So like sometimes people think that we are bewitched. They don't know the actual reason why you become like that... and ... for me, it was more like an eye-opener for a lot of things.

INTERVIEWER (Male): So, this that you are talking about was more like an intellectual level, you know, the knowledge that you have gained and the training and all of that. And how does it affect you emotionally?

PARTICIPANT 5: Well, emotionally, it made me feel. I don't know... I said that... because of the way we judge people because it is not based on any, any facts and I don't know it is just myths. So I guess, ja, it is just that ... Ja, more confused. More like .. I was happy to be part of the course so that I can get the knowledge so that I can go back to the community. Yes, I also had some sad moments where you talk to a guy, a man who has a family who suddenly had a mental breakdown, a nervous breakdown. Like I have my uncle, he is married, has children, but he used to smoke (I don't want to say ganga) ... dagga. And he used to smoke dagga. And we also thought he was bewitched. It was very sad for my family, because to some extent he was a ...It was very sad for them.. He was mentally ill. Only to find out that the guy had ... substance induced psychosis.

PARTICIPANT 6: Okay, I can clearly say that when I first entered I was scared, because, only because of what you hear from the outside.. You will hear stories about patients attacking you, the whole boring story and so I was so fearful when I came to ... that I was going to be kicked and hit, I was going to be smacked and x, y and z. Well, my experiences have been as everybody's, positive and negative. I have

had happy moments where I have, especially with the long-term placement where you're placed for like six or seven weeks where you see a patient psychotic and you can't even interact with that patient and you think that patient is never ever going to come right. And then through your help and through other staff members you work with that patient so much and at the end of your placement you find the patient in a state where he can go out there and do something and do something with his life.

And my sad moments, also find a lot of sad moments, involving the family mostly where the patients are so dependent on drugs, especially they are so... you can see they're good people, but because they're so involved with the drugs there's like very ... for them. And that is very, very sad. And that is when I was working long and short and acute. Now when I'm working all round. When you just feel a sense of hopelessness because you know that they have so much potential, and because of drugs, and you feel sorry for that patient and you feel sorry for that family also.

:INTERVIEWER (Male):Just this one question. So what happened between like being scared coming into the system and being happy? What happened in between?

PARTICIPANT 6:Oh just experiencing it for myself,:: Being there. I really see that every patient is not going to hit you. There is one that want to, but you learn how to deal with that. You know that that patient is now close to becoming aggressive and you're taught in class how to deal with that. So, yes that is how I dealt with all those fears it and all those fears ... away. And now early morning I just wake patients up even though they're all sleeping ...

I'm always placed in male wards and other people always ask aren't you scared to go and wake them up? ...I just go and wake them up.

PARTICIPANT 9: I had an incident because the patient .. were not on the ... and also twist my wrist. That day we actually sent that patient to the high care. Two Sisters... We had two students and one Sister and we're four of us to bring that patient... after that the patient was fine. I don't know what's happening. Suddenly the patient turned and then the doctor just ... and I just washed my hands after that , I come out and then he twisted my wrist and ... And then after that I get feelings like until now I don't like people standing behind me. That feeling I can't get rid of. Even now. Some people standing... I just don't like that...

INTERVIEWER (Male): Any other feelings that you've experienced?



PARTICIPANT 9: There ... and just like wake up at 2:00 .. would go back to sleep again. Feelings? Scared.

PARTICIPANT 4: Me, I was stuck in the first semester. First, I was going to placement in first semester also in ... but like along the way I find myself and you finally ...those patients ... that's when that comes at times because he is ...this guy he is a big guy... guy ... we had to come back. The guy has to every second year. He calls his mom. His mom and father are divorcing. So kind of like for me ... but we ... but I'm looking forward to it here. I'll call it challenging. After seeing a counsellor I'm trying myself. Because there is one that is controlled trying to help... [inaudible]

PARTICIPANT 5: At first after the initial phase a person is short-sighted. For me, I wanted like... I was looking forward to start psych. I wasn't scared. Then by the time I started here, I was like ...there were two ... I was there first and then they came after me. It was sad for me to see to the patients. Sometimes I would cry, then I would go back home, sleep and don't eat. I would feel like down. I don't want to talk. But as time went by the information from school ...I was starting to understand where the sicknesses come from. So for me, like a participant said, it was an eye-opener. So as currently now I'm working at forensics. I am still not comfortable with the patients there. With some of them they ... people. So, I'm still not comfortable. Otherwise I'm doing okay. I'm coping.

INTERVIEWER(Male) : What do you mean if you say uncomfortable?

:PARTICIPANT 5: Usually the Sister in charge would tell us to go and sit with them and take the ... For me, I can't go.

INTERVIEWER Male): You can't go? You're still scared?

PARTICIPANT 5: Yes, I'm scared.

PARTICIPANT 8: With me, I was interested to come to mental health setting, but now given the orientation I became scared. to the extent that I wasn't coping. Because quite a lot of studies ...doctors have been studying patients and ... yes, and then my first placement was... and I .. mental ...right to the ... the youngsters there. I am not an emotional person. Yes, it is sad. These youngsters... sixteen year olds. ... I'm thinking of the future. His hands... I haven't ... emotions and happy emotions.... yeah, but otherwise I thought okay, he is joined to psychiatric settings.

Most of the patients ... settings... I was forever ... He tells me a lot of stories. What he does at school. Most of the time I enjoy myself and I always have ... and because of that ... But otherwise as I went on, I came to forensics. Yeah. ... You're thinking of ... I'm starting to being uncomfortable with the patients, especially if you read their folders cause what he did and why he came there, because some of them, you see this other side of them and tomorrow they are this person, totally different. I don't know what triggers that. But if you complete ... from what I saw at my first experience in forensics. So you think to yourself, what if tomorrow is my turn to get.. you go back and tell your team every day scared mentality but... I don't know how many months now I'm in forensics, but I don't give them ... and then they don't accept any ... You just like find a patient mental health care practitioner; not social but otherwise the experience so far has been good ...

PARTICIPANT 6: Just to add to that what Participant 8 said; I'm working in forensics for ... it is my second placement. I had that same feeling that like you had. That these are murderers, rapists and. all that. and I knew this with one of the staff members there. And he put it in such a nice way to me. He told me that all the crimes that they've committed they were sick at the time. At this moment they're not. So that's how I kind of divided my fear of them. I was very fearful when I got there so when he came up to me you must always remember that at the point they were not on medication and they were sick. And like now they are stable and they are on medication I became very attached to the patients and because you understand their mindset at that time and they weren't themselves. And their being on treatment for all of these years, you kind of get the real thing and not the person who committed that crime.

INTERVIEWER (Female): Just to interject there. It sounds to me the staff was supportive by explaining to you why the patients are there and to try and make you feel more comfortable in the ward. Did any of the others experience that type of support?

PARTICIPANT 9: I have experiences that are very good from Valkenberg. I actually start learning psych knowledge from them. I found how to write a nice test paper, how to study from your book and how to analyse the patient, why they're having that behaviour now and how to manage it... Actually, I am like very much the same... so I am like very close friends with them now. So even now you say to me, where do you

want to work? And I say Valkenberg. They can teach me a lot. Whatever you ask the Sister, they support you. And when I visit, they keep me safe. And there are two male nurses watching you all the time. They're standing here to see if somebody comes behind you, because some patients they have really like impulses. Impulses ... so they just keep you insane. And they say, turn or come this side and then you feel, okay, I will come work in here. I feel so free and sometimes wherever you going or working or get up or whatever, are you here now? And I say, yes, yes, I'm here. So you feel so comfortable. And they don't boss the students. And they don't like interrupt you and say this student is nice and that student is lazy. So ... [Laughter]

PARTICIPANT 8: You know, for me it is only nice there. We are ... with our situation. Yes, people mind their own business. You just say hi. No-one gives you orientation or anything. Just ...and ... unless now you have to stand up and ask permission relating to the appearance... otherwise I didn't get insight...I don't use... [inaudible] enormous. yeah.

PARTICIPANT 7: I am ... I work for the ... they are not supportive And then they submit... here every day is the same. And so stay ... to ... evident support us with medication, managing the patient. I remember the first time I came here I thought maybe they were like a bit too harsh to them. You know... But the other part is that they're all like that because... and so I learnt a lot from you. To set patient you must be not like... you must be firm. You must know who you are .They are just people, although they are ... so ... one of them are ... make me go on until ...

PARTICIPANT 2: I understand what he is saying and I could relate what participant says. Yes, especially in the forensics ward. Even some of the staff are scared of their patients. Now you're a student, you don't even know what exactly you must do. Because they are scared and those who do are lazy ... and so .....

INTERVIEWER (Male): How did it make you feel?

PARTICIPANT 2: It made me feel useless. Also also thrown into the ... you know, I think it would be better if we had maybe at least like our supervisors, a male supervisor, especially in forensics, a male supervisor, maybe ... [Laughter] because some of those guys are scared of the patients and then you see but, okay because sometimes you make it ... and then these female nurses are also scared of the patients. And you happen maybe to be the only male in the ward or you're the

second person is a male and then even the guy is scared of the patient. Now in the end the male nurse is not nice to you. So it would be nice to have our supervisor come in meeting once a week or normally twice, I don't know, but give their support from time to time. :

INTERVIEWER (Female): Just to get clarity. So the supervisor would be in a supportive role. But you specifically mention a man. So, with the aggression, I assume that it is a man would be able to defend himself... I am assuming...

PARTICIPANT 2: Yes, because I don't think it is necessary for the person to have a person to support you who is also scared. So having him there, the supervisor...

INTERVIEWER (Male): I just want to ask you, what about the role model?

PARTICIPANT2: Yeah, also. Also. So that you can see how ... and then also now you can also make him learn from what he's doing and also ... yeah...

PARTICIPANT 6: I think to add here, I think from participant 7, I think you also pointed out the ...about does it have to be a male? I have never been placed in a female ward and you know, I have gained so much confidence with handling aggressive male patients that I have ... how to handle aggressive female patients. You can see any male ward I will never be intimidated by them because of all the skills that I've gained throughout. So I cannot say exactly a strong male person, because a skilled person who knows how to handle and to give them that guidance or something like that.

PARTICIPANT 7:Also in forensics again. We were facing the beds of the patients and one lady, she is very experienced and she is working in Valkenberg for so many years... and I notices she dropped something and went she went down to pick it up one of the patient, a big guy, he said, nurse, you must not bend like that. and that made her frightened and she ran away. Now that's where I think where these big men will come in because you won't believe but they are scared ...

PARTICIPANT 2: : But as my colleague was saying , we are currently working in ward 11. And I hear the stories. I started there on Monday. I heard the story that the one nurse was raped. So I got scared. So for me, for students they should be like assisted. Like you were saying that the supervisor should come and then explain what is happening in the ward. Because I only came there and they expected me to

give the medication. To do the .. like normal. They didn't tell me anything. So for me, it feels like ...by giving me an idea about the ward would be nice so that we know what to expect, especially ...

INTERVIEWER: (Female): Do you expect that from the supervisor?

PARTICIPANT 2: Supervisor and staff.

INTERVIEWER (Female): Okay, can you tell me what would you think would be supportive? How could we help other students to make this whole experience okay.

PARTICIPANT 9 : Because like we will discuss what the placement is and I will ask how the placement is and ... that side say some stories happened and is scary. And sometimes they could... your course.... Even now you learn... and two weeks is fine. .. and the next time you will learn ... and they put you there. That would really help you when you study the course. For now like me, now that I am totally outsider... they put me first in IDS ... I don't study that one. I study like schizophrenia .. and that one and then after that that the course trying to... I just ... to general hospital... so I don't have any experience. They then ask me to write the test. How do you answer that question. I don't know where to start. And then even the lecturer gave you the story just like the ... is not helping him. And then sometime you're writing, but its not the test you need. So I'm already confused in the first semester, but I passed; not getting the high marks.

But this semester you're starting again, but we couldn't do general again, and then IDS again. I don't even know what's the reason. Should I be... so I feel so confused about this year.

PARTICIPANT 1: But I think the kind of support that we need just ... when I first started the person was here and I remember because of all the stories that I've heard ...sort of patients and how to deal with it and so. It made me very scared of patients. I didn't want to with anyone. I didn't want to do any of that or something like that. So I just stayed at the nursing station the whole day and just looked at them there and then if I go to the other side, I made sure that the Sister is there with me at the back. Just to make sure that they see me and come to me ... always like at the back... so when I change there now I'm going to ...this semester to ...there I met a student in the ... interviews the student and [S] spending time and telling me her story. And she had the first experience also. The same story like me. And then I like, okay, what do

you do then? Okay, this is what I did. She actually took my hand and said, come and see this time they won't hurt you. So she had the patient standing here, and said, come talk to me. I'm just standing there. So I say, what must I say? [Laughter] And then she'll tell me and now we started that way.

And then later on I started engaging with them like we had a basic...first semester to do in the first semester. Now she gives me things like how to talk to patient according to the [...] so now I go to them and ask them questions and now see with that happening that same [...] that I had at the beginning. After a while she ... appeared most... of the medication I was asked to go to them and ask them questions. And I talk to anyone of them. Even now I was scared. So I was hoping so I got confidence ... I don't care if anyone is violent or what. [Laughter] But now.. I think this kind of support like having so much and shared like this they should actually physically handle say things that is very important

INTERVIEWER (Female): Just to get clarity; that's someone you're looking at, are you looking at the conserve or somebody who is in the services ...?

PARTICIPANT 1: It can be us staff or it can be conserve, it can be, especially mentor...most have got mentors ...is physically ... I mean that way.. that person is supposed to be here, because when you ...for the first time you don't know what to say to the patient. You can't just say the same story that you said during lunch. So you need someone to show you how to start that ... and actually how to identify what you're supposed to. So you think the patient is clever, but he's actually a liar. I had this patient that told me about a friend. He told me he was doing his MIR and that he was an engineer.; that was basically; computer things. So we find out that he is schizophrenia, is actually something about that says something was not clear. So that day, I went to the Sister and I tell the same story and she was like, who told you that? [Laughter]. [Inaudible] No it was so cool.

INTERVIEWER (Male): Support?

PARTICIPANT 6:I think the support should come from that very first period that we had the orientation where the lecturers basically tells us about the course and x, y and z. I think you should add like a support; what we're going to experience in that and then also carry that throughout. Like you know, maybe in between the lectures we could have times and ..., I know our lecture times are already limited, just in that

time have a time maybe those who experienced something bad within that working week. Because you know, you work first and then we have class. And then we can get it off our chest immediately. Because so much things happen to us at work and personally that's why we do like bad in tests because that thing happened to us. So if we have that particular time just to vent and just to get it off our chest I think. that would also help. So in the beginning in the orientation period, enlighten us about what to expect. Forget about the stories that you heard. Nobody's ... There are .. patients, but there are people around you who can protect you.

And then also once orientation right through the year because through the year you're actually experiencing those sad emotions, you're experiencing that whatever that thing is. So I think we can also have a time, you know, ventilate and speak about ... even if it is a half an hour before the lesson just to get that out. That would also help. I don't know how the others feel.

PARTICIPANT 9 : Sorry I just want to ask one question and get it right, get a correct understanding from... She mentioned about lecturers. I want to ask her a question. Are the lecturers supposed to support us most of the time or is the supervisor supposed to support us more? Which one should more?

INTERVIEWER (Female): That's what we need to find out from you people.

PARTICIPANT 9: Because I can't say where these lecturers are telling me that story. But after I get depressed I go to see my own lecturer. He told me that, I'm not going to work with you all the time. You have to speak to your supervisor. And I found my supervisor has like a lot of students. At that time they have evaluations and they have some practice ... and if I can't speak and afterwards and also the other feelings from crises...also from school work...you know how many times you meet them in group numbers? You know how many times you call them? You are very stressed. After school, after work, you phone them ...and then you decide .. you don't work. You don't know what to do next and when the exams coming and you are just freaking out. And all the people are coming that time. Only that time because it is exam time. Don't worry, you will pass. You will pass. I'm like, okay, how do you know I will pass? And then even I don't know... but I am the person I know how much I study, I know actually I ... marks.

But the first test of the first semester I only get 20 something. I can't believe that the ... each lecturer gives you different things. And they're marked by multiple lectures. For instance, our lecturer gave me this story and I wrote notes in my books. And then when I answer the example, the test, exactly answer that one, but the other lecturer gave me 0 and I speak to them and they're like treating me like a ...they say like you go back to that lecturer, I am not marking. And no, you're not my student. You're not in my class. In my class I speak this way and ... Go to your own lecturer and I come back to my own lecturers, and you don't have time actually. And you have to send e-mails to make an appointment.

And after that I go get my lecturers. It's anything like three weeks time. You're finished ... You can't much more. And even that time my lecturers are still telling me, I can't help you because I know and as I marks ...Then I show her the books and say, this is what you're telling me in the class. And then she says, I can't now. I can't now and then she walks away. And then you send e-mails again to make an appointment. She just walks away.

And also my other subjects, because I'm a different person, the lecturers is marking my marks me. One lecturer... I get 90 something; the other marks me, I get 60 something. But the same work. I still wonder how it is happening. You feel like you tried your utmost... even now that because you have to work because I need to finish the things, even the research. So all these things come together. Monday you just walk in there and come Fridays you're worried am I in the groups, you're asking the lecturers, and you're going to them and asking questions – just one day. I need that one day.

PARTICIPANT 4: I fully agree with number 6 that the support from the lecturers, supervisors should be an ongoing thing, because, yes, at orientation they gave us something about psych. That was good.

But I think for somebody ... it has to go on. Something that ...Honestly, at times you really need like the supervisor to support you, as well as the staff. You might find that the ward that you are working in the staff is not nice. So something like this should be an ongoing thing. I think that would help.



INTERVIEWER (Female): I just need to for myself to get clarity, the lecturers and the supervisors must give support. Just specify for me what would you expect them to do?

PARTICIPANT 4: Honestly, I am in class every day and every day she would ask us how do you do. How are you feeling in the class? But I think ... it has happened. You only have to call like seven students for this week just to check on you how are you doing. Or in the classes, how are you doing. I think all of you should involve more when they come here and see us... they must ... and check on you...

PARTICIPANT1: I want to answer the question, because you want to .. not specific on support. I feel very strongly about this because it annoys me sometimes because the supervisors ... you take your supervisors as your moral support; as your comfort, because you're not going to ...how this is going to be. Now when you get this treatment from your supervisor that you're supposed to look up to you. it is so disappointing. I think your supervisors in the Nursing Department are appointed .. supervisors should make sure that people who have patients and make sure that they can deal with students. People who are not easily offended... they have to inform you that you cannot mentor ... and to be able to act on that Yes, so that is my two points. So that the students can see that you aimed at the students. Because I am on a mission.

I've had a personal problem this particular semester. I think she's pretentious. She pretends to care but she doesn't give a damn.. Sorry, excuse me. I didn't like her. Her whole attitude is just off, because you cannot have a session with me. I forgot my book, I understand that I didn't bring my book but ... and I forget the book and me I must bring that book. And then you go to the staff and you discuss me with the staff. You see, that student, I told her to bring her book , but she didn't have her book.. who cares she .. Then I get this attitude from the staff, oh, your supervisor tells us your drinking, you don't do your work, and this and that and I feel so exposed. My back is just hanging and there is no-one there to back me up. I mean, I was so , so, so upset. I think the supervisor should have a very, very good attitude on to how to deal with students, period..

PARTICIPANT 1:You know, the type of support what we need or what I think we need ... I think first of all, I'll ask my question. What exactly is the job description of the supervisor? Is it just come in and check on us once and leave? Or are they

supposed to be here? They ask of us if we're here. like they say that they're here for two three times a week to check in how we're doing, if we are learning what we're supposed to be learning or they just want to check on their assessment of the nurses... that's the first one that ...

INTERVIEWER (Female): Okay, you want clarity from me? That's not the purpose of this, but nevertheless. Well, remember people perceive people differently. Some people will say that the supervisor is extremely supportive whenever I needed her she was available and some people will say, no, although she only came only once a week, you know, that that was always supportive in itself. Some people said that, I've seen her everyday but she was not supportive. The idea behind the supervisor is beside the learning objectives, even the lecturers, we're all human. we are also nurses. We know what you are going through. I mean, we are here to make sure that our profession continues. That's why we are training people. We need to train the next leaders. So if I'm not a role model then what am I doing here? And that goes for the supervisors as well.

PARTICIPANT 1: Now the reason behind that questions was that I was looking for the whole year the kind of necessary support that I have seen from the lecturers and then I checked because of the work load that each one have, and the allocation that each one has to actually give fullness to that job description. As ... mentioned, once a week lecture. each and every student have on this specific lecturer and I think that's a lot for one person. One day she's on and plus it is a lot. And when I look around for supervisors and they have 200 and something student s and they have to run around... that I think is also a lot. And if you expect them to be here to be ... taking your hand that won't be that effective also. So I thought how can we make it better than this... somehow from supervisor and lecturer... So I ...having hospital I heard about mental hospital ... I never saw any so far from the staff since I'm here. I never saw any. They say they are here for the staff. I never saw any.

Now the idea was is it possible to have the department of a structure that is on its own that is called support services for nurses and students? To me that also needs staff that are there to mentoring students in their facilities. I think that would be more... It would allow the lecturer to make a difference... the supervisor is we're her ... so if I have this kind of problem then I know which one or that one individual would address the issue because this makes their whole life easy. Because now we have

people who we do not know any...or what is actually direct... because we speak to someone and we're told ... that is not my job. They call and say to that one go there and they say, oh no actually... You see, that makes the student confuse because if you have an appointment where to go to get the proper assistance that you need. I think that also is a problem

I also look like a kind of work and you were saying that he wants to be the future generation. I was thinking, okay, you want to build a strong nursing staff and also s... service also. It also go into the well-being of the person and say that the person is good mentally. .. So, if you have all those elements, we need, okay that's what I think, you need specific social ...such a ... that look at the way, okay, first our study schedule. I am working, studying so the team all together, and then you have one day class and here at Stellenbosch, and then how do you cope on research and group presentations and everything. Is it possible at all in your own in that way or is it not? Okay, for some people, okay, me I am making it working without any .... But physically it is strenuous. It is affecting a lot of people, because you have Saturday and Sunday. What do you do? You're are still working. You're not realising that you can't even sleep because some people can't sleep. Because for those all the people, when they've finish working here when hey finish at 4:00 that means the ... . you finish... but you still have that and that before you get to sleep sometimes at 12:00. You have to wake up at 5:00/ Those of you ... because you're working again, you see.

INTERVIEWER (Female): So what you're saying is that it appears that the work load in addition to the theory and the practice is just too much. Is that you're saying?

PARTICIPANT 1: Yes.

PARTICIPANT 6: To add to participant 1, I agree that we need a specific structure. Not somebody employed as a lecturer. Not somebody employed as a supervisor, but an independent person where we can go to if you maybe had a bad week if you not coping. I know there is tutors' support and all that, but none of us use it.. I mean, if it is just for nursing students and maybe with someone who is a nurse and has been through the whole process and knows what w are going through someone we can relate to I think it will get easier. As Participant 1 says, I think it is difficult because I think the stresses of work. The stresses of varsity and our own personal stress. And

if I had that particularly person to go to, someone we can trust and can relate to. I think that will help everybody.

PARTICIPANT 3: For me, I've always found it is basically what 1 and 6 said, I have always found speaking to a person with nursing experience helps me more. It helps to speak to a person lay, but it's different. When a person understands exactly where you're coming from its just... I remember first and second year sitting and just speaking for hours on end about the day I had, but I felt relieved. I felt uplifted. And then kind of you get to psychiatry and not ...most of the people have that experience. So it is more difficult.

Student support services, I've been there. I went there to make an appointment at the beginning of the year and they said, I can only see you in two weeks time. And I felt like I'm going to break down now; not in two weeks time. And then they said, we can only see you on a Tuesday, and I kind of I work on a Tuesday, there's no way for me to come and see you. So I just went another route. So the very idea of just someone with listening skills. Someone who can accommodate us ... our busy schedule as nursing students.

PARTICIPANT 9: I want to add something else... like the first-time students... they don't have like physically very strong. Sometimes they get lots of sickness. And how the system like the university will protect them. For example, like for me I am very sick for this semester... six times... I did a very... I know I'm not a person really like ... when I get sick I can wake up during the night because I can't breathe. I get this.. . what do you call it? Bronchitis, I think, but I don't cough, I just can't breathe. But I ... I just can't breathe. Sometimes I go upstairs and see my face has turned very red. And when I work in a team I just like breathing like a ...setting. So I .. two weeks later.. because you have to work and you have to go to university and you have the group work, and people don't think you are sick , you even have high fever. You don't know you're sick. After that I went to the doctor. He said, you need to sleep otherwise you will get...infection deeper. Okay, I still didn't sleep and I take medication afterwards to get better.

But you know, for that sick and if you didn't go to rest again, and you get sick again .. and I get bronchitis. Actually it happens again. Another day I get a bladder infection. I come here. I go to [R]... because I need to ...in the toilet, and the pain and the

itching and after that... I think between.. I don't have time to sleep. I get a lot of things in my stomach.

And this semester it was sick, sick, sick, sick. Even I go to speak to my own lecturers, I'm sick, what can I do? No, you are in trouble. You can't write this like sickness, sickness. You know, even the you can't write the sickness. I'm freaking out at times. I don't know even ...then I get a certificate. And by that time... they say, you see, the other student, they just write a test and then they go to the ICU, heart attack that one.

And recently, like two months ago or one month ago, I heard a story of a student dying . I was so worried. I feel you oh, my word if I ...hard work... I also maybe get a heart problem or something else. I feel so frightened and nobody is like asking you, how're you now, are you sick, are you okay, do you want to go to ... send some e-mail to you and you will get work. Then e-mail your work and your lecturers say, no, I can't; just read your book [Laughter]

INTERVIEWER (Female): You feel it is not supportive.

PARTICIPANT 9: Yes. And then you know of course you ... students... but now with the first years I can't.. but fourth year if you're asking someone they say, okay and they just go. [Laughter] So I feel that I can't get help. And even if you're asking your supervisors. Different supervisors give you a different answer. And you are scared to write in a test that it is going to be wrong. So I definitely don't know how I will cope with the situation.

INTERVIEWER (Female): Okay, but now if you have to think what we could in place to support you...

PARTICIPANT 9: Okay, firstly, the .. I can see you are very nice, because you are helping me a lot... seriously, you have helped me the other day with information. I feel the lecturer must be there. Otherwise why are they lecturers. If they don't want to help students they will always tell you, I don't have time for you. I don't have time for you. Why do you be my lecturer? I paid this monies by myself. And I paid all fees. Even if you don't have times in your consultation times..., how can I do? And also please the lecture report ... the e-mails you can't ask your assistant or ask somebody or ask some people to help you. And this student .. it's like asking to see you, but which time? All the lunch time you were also in the lunch.

And also the supervisor information for evaluation, I think before they start this year, they must have the same answers. Otherwise that supervisor gives that thing. That supervisor gives that thing. And when you run to ask them... you're not alone. Asking, you don't... the whole year your marks were... we have to bring it down. But asking ... you feel it is unfair. You are just a lesson to your own supervisor. And also the other lecturer... to your own supervisor you have to ... the other supervisors see what they are talking about.

But I want the time that I could talk to her and even when you need them. And do you know how many supervisors there are? So I suggest you make a board like clear everything out which supervisor, which office with their names, their times they're free, and the e-mail addresses and everything is put on the board, and the ... if I have problems, oh, it is here and I can just contact because it's here now.

And also the information about your study like your course... before anything, please clarify. Don't give to us all the information for us to write and when you think that is correct and the other lecturer gave you then you write it That is wrong and then I feel like you need to learn something, but the thing is you need to learn corrected things. It's not nonsense. I don't mean nonsense, but I can't use other words to say that. You can't learn nonsense and then you write it in the test. I do that again. I think, how do you do that one? I think I kind of like ..

INTERVIEWER: So what you're saying so that board ... you say that there is inconsistency. What would have been supportive? I just need to get clarity. Would it have been supportive if everybody is speaking the same language?

PARTICIPANT 9: Yes.

INTERVIEWER (Female): If that's what you're saying or if there was consistency across the board.

PARTICIPANT 9: I confirm my information if I say blood pressure if I say the range is 120/80 that is fine. All this must be same that I can't say that one... okay, that one 150/80 is also fine. You get my point? It's like you get confused.

Now also on the board you have to write every person's name, office and contact numbers; not only on the book. Sometimes they change the information and also it cost a lot of time. And also which person is doing which job . ... you need some

[letters], you have to speak to them. And if this is a higher manager, these are something... If it is personal you go to speak to that one. Now I'm like a crazy... I go to the faculties, I can go every office, up and down... after that I can't get my intervention which person I have to speak to. That is my ...

INTERVIEWER (Female): So that would be supportive in general. And in mental health, are you talking about? I just need to focus on mental health.

PARTICIPANT 9: I think both sides ... if you can't, because I know this will cost a lot, but if you only from mental health. Also another information is which places you have to choose on the notice board and where the places are and what the patients like short, short definitions. And we will see.

Because you know after orientation, you ask me what they were talking about. I said I can't understand, I don't know anything. Even the language. I just see okay, they're talking some things, but I don't know what they're talking. So if you put it in the notice board at the beginning of the fourth year I've been there. I know I will see my calendar of the semester. Otherwise I will be asking the other thing. The other person will give me this information. The other person will give me other information. I will think which one will I have to choose. I can't work... when I come back ... write and research... change .. no, you have to refer to two weeks after ... How can I know that information it is not suitable for me when I'm working?

INTERVIEWER (Female): Did the others experience the same? Was that your same experience? That there was inconsistency, because clearly that would have been supportive, you know... is that your experience? Participant 1?

PARTICIPANT 1: What I want to say, okay, for both of us who are not from here, I think it would be so helpful to have like a clear guideline, you know, before going to a class meeting what is happening there. It is like you're signing for something and you don't know what you're signing for. I did that so many times in the hospital because I don't know where it is. I don't know what to do there or whatever... that would be ... that thing sounds very strange. Let's go there. not actually knowing what kind of patient, actually how many, what different patient will see me, and the staff capacity, if they don't have no staff to support students, how you're going to get there... who is in charge. You know, we need to know such things before we're going. Because there we will get clarification that actually needs to be ..because so many times you

have been placed into facilities when at the end of a week you are in charge or you're just students...you don't know ... users... and at that time you need your supervisor to be there, because you don't know what to do also. Something happened to the patient, everyone would be blaming you. There wasn't anyone to get you to do things. You see?

INTERVIEWER (Female): Now tell me, where do you see this happening? Because she said in orientation, the way I understood it, in orientation if there's a lot of information that is being given and sometimes one doesn't remember all these things. You get given names, you choose but you don't know where these places ... where do you see this happening?

PARTICIPANT 1: It might be under orientation. You know, when you get your time table for those two weeks and at the same time you should also get the names of the different facilities, while you are there ... anything that establishes that there are those kind of patient that you are receiving and the kind of treatment that they are doing, and the staff capacity...

INTERVIEWER (Female): So, if we give it in information do you think that is going to work for all of you?

PARTICIPANT 9: Like for instance, the second year when I worked in trauma. You will see exactly and they gave you like what is CPR and what is trauma unit doing and what is the red sign, and green... and I wasn't nervous, because I know what is happening there. If I don't know, I just tell the nurse I I can't do that because I didn't study that.. And the nurse says, okay, standing outside and you'll see. . And you know exactly what is the sequence of OR. And the patient waiting outside, you know that is first and second.

But in psych and I want to read, but when I open the mental health book I said, where do I start? And I look at my calendar. Okay, I have to start on the first page. But when I opened it I said, what's this? You know...

INTERVIEWER (Female): You see, it is almost a handbook. So, if we say we are going to be placed you at Valkenberg, then you have Valkenberg, Valkenberg this is where Valkenberg is, this is how many patients is has. If you have problems, okay. I just want to get in my head to understand and that you would see as being supportive because you would know what is expected or what to expect.



PARTICIPANT 9: Even I go to search on the internet or other books I will seek information. I will prepare myself. Even I can understand what the nurse is talking about. What are they talking about. And then they don't say, you are foolish, go away.

INTERVIEWER (Female): Participant 7?

PARTICIPANT 7: Also you know, this thing... we can't be the same like number 1 and 9. Maybe during orientation maybe after a period chosen the hospitals, maybe the supervisors from those facilities, okay, maybe if I'm a supervisor at Lentegeur, then I have my Lentegeur people, then I place them in a ...this is what is happening so that when they get there, they get their orientation, they already have information about what they're saying.

PARTICIPANT 7: Okay. The support that we're getting from the school sometimes I think it's really lacking some times. Last year, I had a bad experience. I had a fight with a Sister. Surprisingly, whatever the Sister said to the supervisor agreed. Her side of the story was taken last year. My side of the story was not heard. And even until now I was penalised without my side of the story. I think I want to appeal, because they told me, if you appeal...

No, I didn't want to cause any more attention. It's okay. I let it go. I will not... it happens. That's why I wanted to see that they're at least supportive.. Not to see that this Sister is still around... yeah... I really think that ...

INTERVIEWER (Female): So, you felt that it would have been supportive for you if both the stories were heard...

PARTICIPANT 7: Yes. Because I was told that lecturer was ....more. That was true. I think at the time of the meeting they told me no, this is not true. I was speechless. Because that was exactly what happened, yeah. I don't know how they ... but you must look at that matter. Thank you.

PARTICIPANT 4: Yes, it is sad the support thing ... You must remember I had a problem about ... marking. I think nurse should tell the Sister that students ...okay, she was going to work until this day and it works like this. Because a lot of ... the Sister, she is a ... Sister was ... so because you should work with the system. I was just explaining , okay, you're not going to here tomorrow. She told me what I must

do... and all that. We just need the correct support and some support from you. She got angry with me. That I must be ...and I am supposed to come to work and up until the ... come tomorrow ... so I think that is a waste of... it is going to work from this day up to this day. This week. Like ... this okay, this ... then you explain... the Sister is like I don't blame them because they don't give correct information. I was ... because she was saying... who is going to .. So I'm saying that they should be more supportive on those things, seriously.

INTERVIEWER (Male): I wonder how you're coping? We talked about supportive stuff. We talked about our experiences ourselves. Coping? How are you coping?

PARTICIPANT 1:I was waiting for that. I was in placement and I was doing the observation story and I feel like crying and at that time, I just said no, no, no.... And then I asked the Sister, can I do something. She said okay. I just feel like crying with the patient. I just took the patient's hand and the Sister and we cried together. And the patient was fine. And the Sister was fine. So that is how that go – I pray..

INTERVIEWER (Male): 6.

PARTICIPANT 6:... I've tried and balance my time between my studies and my social life as well and not put too much into ...I would never say that I would study the whole day. I would always spend time – me time. Even though I knew there wasn't time for that but I forced myself because I would probably have been like participant 9 today. Today if I didn't tell myself to look after myself. I would also have 10 000 illnesses, crying everyday because we need to know, yes, our course it is important and we want to achieve that, but we can't ...ourselves. Just time for yourself, make a time table up and study from 9 – 10 or whatever for three hours, and then I will have time and just sit and do nothing and then you must always have structure where you go.

PARTICIPANT 7: For me, especially from ... I get an attitude from the staff in the mental health care facilities... I think it was very cold. I was just wearing a rain coat and just ignored them. And not getting enough support from the university ... and just hanging in there all that and hope that everything goes well.

PARTICIPANT 9: My coping is buying a lot of stuff as you said, like clothes, pants, new dresses and that ... time and you [Laughter] and this semester only six months

it cost R8 000 of just buying and buying and my husband supports me and [Laughter] I know I'm very ... person to dealing with some things and I gave up some ... after the other faculty, why? Because I want to get myself some hope. I want to see the light of my life. I don't want to end my life in silence. I want to ... in the future I will be schizophrenic, I don't want to.

PARTICIPANT 4: [Laughter] For me, I mean, like ...general but she knows, she ... I don't know ... I come to ... seriously just going to ...I have come this far ... I don't say that I can cope that way...

INTERVIEWER (Male): So she listened to you and was instrumental in your ...

PARTICIPANT 4:I go to her and talking to her ... she would come.

PARTICIPANT 8: Me, my coping mechanism was, has been ... something... to do martial arts...classes, and I'm managing ... that was my way of escaping the bad situations. Stressful moments. Yeah.

INTERVIEWER (Female): Participant 4.

PARTICIPANT 4: I would love to work in a psych hospital.

PARTICIPANT 8:I would psychiatry.

PARTICIPANT 9:For me, I'm like a bee. I can't find any answers by myself. And the last time you were standing by the door and you ask me, you saw my face, do you have any problems? Do you want to speak to me? I said: Will you help me? And you said, Yes, come, come I have time. You are the only person from this whole unit who...

INTERVIEWER (Female): Thanks very much.

INTERVIEWER (Male): Thank you very much for your participation.

**EXAMPLE OF A TRANSCRIPT- SEMI-STRUCTURED INTERVIEW WITH AN EDUCATOR**

Archival #: IIUWCO3
Site: UWC
Data collector (s): P Martin
Date of data collection: 18 January 2012
Transcriber: N Roodt

Interviewer: I want to look at what emotional issues are you aware of that students face in a clinical settings?

Participant: Ahmm I would say students hmm are our are scared of the psychiatry because of ah hmm they've never been exposed to it before, and ahmm well it makes sense to me because some of them they've never been in psychiatry institutions and hmm ja, then it's very frightening I must say, you can can, you always know that whenever they are placed in psychiatric settings.

Hmm well reporting I'm sure because that I already know. you know that hmm its its very difficult for them. I always identified it with myself. You know when I started doing psychiatry I didn't even know what was it all about. So I know what I went through. So then what I usually do I put myself in their shoes, so that I can be easily you know, hmmm, to help them because as soon as I pick it up. No, this student is going through this, I say ok, now, now I know what is going on. So what I do, I I call the student and I assess the student myself. Hmm what is going on? are you ok? and are you relaxed? Then they started you know explaining that hmm look I'm scared of this in the ward. And patient pacing up and down. I'm scared because maybe I'm gonna be attacked.

Then I start it from there. Get to explain this is hmm what is happening, Patients are there because others are violent, others are doing that because they not well. So you don't always have to think you in danger. Because that's what you here for, is to learn rather than having fear.

So in that way then it's the way of giving emotional support so that they can hmm relax. Ahmm, then if then I can see they that they not relaxed and still very anxious, then I always wanted to find out more. You know [laugh] Sorry to say that, when I say more, it's obvious there's an underlying issue of why that person doesn't hear what you saying. Then I build trust relationship then I find more [laugh]

Interviewer: Ok It sounds like you that was our next question sounds like you call them in, you talk to them

Participant: Yes, yes it's what I like is that. When you see them in clinical settings remember we go to each and every ward. So then you, you have that opportunity to see them one to one.

So it's obvious when I pick it up that ah this one is more anxious or even if you ask straight or silly questions like, how is it in the ward? you ask questions like that. So you expecting such as no it's ok, its ok, Ms Dudu. Hmm then ask the second one. The second one said hmmm you know, you know, then you have to then, I have to find out that hmmm what does it mean? Then the student will start explaining that yesterday they, there's incident. This is what happened and I'm very scared for this patients. Because firstly you know, and then it's when I started to get into the diagnosis and I engage the student. How many student? how many patients are here? what is going on in the ward? do you know that? because if you don't know that then you not going to relax because you won't know what is wrong with this patient? Schizophrenia? what is wrong with this patient?

So if you know that then you able to to to know what's happening in the ward and that will alleviate your fears and anxieties and the, the students starts to ok, ok, Ms Dudu. I will leave you today. Then you know I'll leave it over to you and when I come back, so I'm expecting you to tell me what's going on in the ward. Then what do you know about schizophrenia? what do you expect, the behaviour of that person. If you say that patients got bipolar affective disorder, what do you mean by that? and what do you expect when you say manic? What do you expect from a manic patients? then the student will start to say oh oh then only oh no wonder he was just doing this this and this. Then hmmm engage yourselves. That's how I do it but it works sometimes.

Interviewer: Ok have you ever found cases where students don't cope even although they empowered they know there in your experience?

Participant: Hmm well hmmm I did come across with hmmm students that were not coping. but I must say because of hmm, I always make sure that if the student is not coping as I was saying that I will find out more. The student is not coping because of what? What's happening? Is it because of he doesn't understand psychiatry? or he doesn't understand what's going on in the wards? or maybe it's something outside.

So hmm well ja, here I did find them but of because I'll always put them first on the list, then I follow them up. Then at the end they'll ah maybe I don't pick it up any of that fear or giving in.

That's why at the end I always do my own hmm finding out from the student if hmm how do you experience psychiatry? I do that on my own and hmm ja and the student said well something not all of the [laugh] they said because of we we sensing something that you like psychiatry. Well I don't think I'm doing because I like it. You know I'm sure it's within me that I hmm it's the way of of empowering other people in order to understand things. Not that I like it and the response will say those who hated it, like students said I hated and I ask her. Said well I enjoyed psychiatry even though I will never go back to psychiatry because I always think you. I said what did I say or what did I do? I say well you you show me that, that I can. Even though I was like this, is not what I like and all that because I always tell them that it's not a matter of you must like psychiatry.

I've friends who I study with, four or five of the friends together. They've got nothing to do with psychiatry but hmmm because of you know, they know that that's have to learn and understand. Then the student understand it in that way that have to. They have no choice. but hmmm they must understand that its psychiatry is the basis of everything wherever you go to help you anyway. So that's what I always make them understand, and they say wow is it true and I say yes, you will give it a try.

So the student hmm I met and ja then they, he ended up in Lentegour and when I met him sometime and then I said how did he enjoy psychiatry? and then he said well I'm doing very well. Then I say, remember when you said you hated psychiatry and you don't understand why people must do this mad, so called mad people then I

started from there, what do you mean by saying mad people? Then I started unpack, then the student said what did you mean by that? Do you see psychiatry as something that it's not real? or do you see that it's a something that is you you've never come across and then the student said no not really and then I said ja, ok, you all have problems and that we encounter everything people that get hi-jack, divorced and all those things. Also end up having depression and that is reality. And then the students say oh wow saying in that way oh that's ok.

So I always have ways of making them understand. Not the one in the book, the one outside the book and then encourage them to identify important to cope with psychiatry that you must always make sure that you first understand in that way. You reading it, the book is just a way of complying and you see what you know is true, then you link it together and then it work

Interviewer: Sounds, it sounds like they see you as a role model and if you can do it the fact that you supportive they can also do it-is that it?

Participant: ja, ja, that's what I was going to say. That I always that I getting it from there. I, I am a role model to them in terms of of how things are doing by saying, look this how I do things and this how I'm expecting you to do things. If you not going to be on duty or whatever, sms me or do something to me and then build that trust relationship on there. It's part of of of psychiatry.

You have to take responsibility for yourself and to others, also around you and in terms of work. Ahmm, you don't report to me because I don't work in Valkenberg. You have to report to the person in charge. So if you report to the person in charge if I go and visit you in your ward then that person will report to me. So there's a chain of of of who reports to who, and then if something major that you need me to give you support then call me, but please don't call me at night. Which is they do call me early in the mornings whatever and all those things.

So hmmm role modelling that I know that's what I'm always doing to them. And hmm the role modelling also hmm make examples of my own incident what happened to this? what was happening in hospital when you were giving medication one sister was doing this. The cupboard was open and this and this and this you know so I always make examples of a reality of the real psychiatric nursing. This what is happening there.

Interviewer: And I think the mere fact that you have also given them your cell number because you say they can call you as well that

Participant: yes

Interviewer: in itself is supportive to know that you can call someone

Participant: yes

Interviewer: Tell me are you aware of any existing support services that we have for students?

Participant: Ahh well at UWC hmm I must say that ahh there was a student who he was hmm going through a crisis with a sister and the sister was raped and all that. It was quite frustrating because you can't get through who to talk to and then it ends up now you know carrying this load that you need to you want to give to someone else.

I phone student centre student centre. Nobody could ahh refer you to anywhere. I even ask psychologist or psychology department. I was referred to them also. They like I couldn't get anyone one to assist with this student but I managed to support her through until such time that hmm she was ok. She finished and then we managed to carry her through and otherwise I don't think so I I would have ever referred because I don't know who to refer to. but I always tell them go to the student centre, you registered here, so they can assist you. They don't go. They come back to me with the same issues and problems then I use my skills of giving emotional support

Interviewer: Hmm ok tell me what do you think the clinical setting can put in place you know to support students?

Participant: What I can think can put hmm in place [pause] thinking of for the students if [overlapping interviewer] If it were an ideal world you know [participant: hmm]

Participant: Well firstly is to avail ourselves you know as academics you and also clinical supervisors, everybody, and then availing us mean that hmm when it comes to giving the students emotional support, we always have a better understanding of how to deal with that with their issues and also where to refer.

Like in this case that I, I don't know where to refer them in a case where they need intensive counselling. So then not rather than ending up hmm you becoming now



psychologist or whatever. So if we can have a link. It must be clearly stated in the department that because the students that ah ah I must say that I being ah I mean at a university they've got lot of emotional baggage. That we know for a fact that majority of them are coming from different back grounds which is hmm tsh underprivileged that we know.

So on that on its own it tells us hmm there's allot of things that we need to deal with. Hmm including your pregnancy, yoh including all financial problems, ahh including all some of them socialising out you know, things like that. Not coming to work, including I can name lot including that everybody knows that they are working.

Because one time student I I visited hmm in Kenilworth because I worked there also for many years. I saw my student there. She freak out, sorry for the word, so, so because of I learn that [hmhm] so the way of dealing with someone else you know. I called her because ubenni called her for some other things and all that. Then and then I was passing some of that then I saw but the only things as you are saying that the, we can, we need to understand those things that ahh they need emotional support. So rather than me saying you are going to, the only thing that I was concerned but are doing well at school? are you coping with your academic work? and then she was very embarrassed because when I was saying that because I was like I'm not concerned with what you are doing here.

I mean you are a staff nurse and I know now that you are working in this time and, and when she was doing not well in the setting she came back to me and said Dudu and I said look can you remember that question that I ask you? Remember I ask that, that you in life you can't do things all in one time because when you are qualified we can do anything in your heart. But in your case when you finish your degree if I'm right and you after that can do all this things of moonlighting and all this things.

Interviewer: Was she moonlighting as a staff nurse?

Participant: Yes as a staff nurse. Because when she was a four year student in her final year working. A very heavy ward. Then she was working in hmm in a adolescent unit which is heavy, you know. Then I said how, when you sleep? You know she was working night duty. She wakes up in the morning and go to gender base. She failed gender base. So when I was doing that hmm invigilating hmm egender base, saw her sitting there she was pain then I'd rub her back because I was like, please write it

right, because what I need you to do is to pass, and so I'm sure everybody knows, that you know that they are moonlighting. There's students, so where are we putting things like in place so there can be an open thing where you know they can get emotional support, that hmm we understand circumstances, because she was saying that she's married and she needs money to support now you know. I hope she pass. I was going to check up but her name not called.

Interviewer: What we could put in place or what could the clinical you know the services put in place to support these students?

Participant: I I well if we would do everybody the same. You know that of hmm yes I know I'm here but most of the time I'm, I'm here for students to see that they successful that is my vision. Well we failing them. I don't think so that that so when I give emotional support to each and every student irrespective of the race or colour or creed or whatever this is what I do that. I got feedback from them whether you black or Indian or whatever I treat you the same. If you wrong I tell you no, no, you should have been ward one. I placed you in ward one but why didn't you go to ward one? Because now Sr O'Neill is phoning me but please go back to ward one because that's where you placed.

So I don't have no favours of whether you black or what, African or whatever. You, you they know that you when it comes to work and it must just be done, we don't have nothing. So if we can have you know, it can be enough unless ke, it they can have other services that I don't know. That we have to put into us as something that it must be something it must be there. We need to be role modelling so that's it. This is how things are done and this is what needs to be done and [pause] role model. Don't look at those who are already qualified but a student of mine, eh the one who reported that sisters leave at three. They leave at one. She came back to me, Tell me that she did say that ah sisters are leaving at three and two. And I told her "look I work from many places because I went from Khayalitsa. So time I work as a community nurse and whatever, I, I work there because of I I was working in a place where we were few and leaving early or go and have lunch at two. I don't want, I did that, all that but when it comes to patients are sitting there, I always start with them first.

It depends how you doing it so I'm trying to to explain to her that it is saying I'm doing it because of sister leaving at at one and come back at three. I say I'm not saying that

I never did that. I might be doing it but it depends how I'm doing it by doing stuff or you just leave it. Patients, fifty of them there and there you just go to tea from 9 to 11. I've never done that. I've never done that. I do the patient, I do that. I go to triage, I work and I do that and things. Said no Dudu's still busy there and do that after that I go somewhere and I ran and I come back. I finish it up and then at four I leave. So I not sure of when I was taking two hours or one hour.

I'm sure about that but I make sure that what I'm there for I'm doing it. So better if you doing it that way then it would be ok. But if the sister who is in charge of the ward is not doing that way I don't think it would be great. Just turn a blind eye because that one is not showing you the right way. So it's entirely to you what you want to learn then she said ok right.

One time, one time I always go way in Khayalitsha, she was involved in a big mess. She was caught up putting water in a in, a in, a whatever and I was told it's UW student, the same student.

So that's why I saying that you, you can role model them but I always tell them it depends who you are. I can tell you how to manage things and I say especially if you go to work in places like eKhayalitsha. They will let you do things and at the end they will turn round and no good come you. This so I was giving on the tips of how to do things you know, but you must be careful. You, we, we will all eight of us go and disappear and go to Mitchell's Plain but only one person will be caught out.

The student others tell me Ms Dudu we we we thinking of that then I say good I told you never done anything because of someone else's doing when especially in in our profession. So some of them I'm meeting them, they took that as as as a role model that Ms Dudu said we must be smart. We must do this things, we must make sure that patient comes *first* [clap hands] patient comes *first*. Even if you are going to lunch, make sure that patient are sleeping. Make sure that you are going to do this. Make sure that you tell that person that you going to whatever. You going to come back if you got time. It's between you and that person. And if they don't want to do that, I tell you going to have big trouble and when in trouble you won't even be able to take yourself out.

Interviewer: Hmm. Ok just to come back a little to where you said something about others services besides role modelling you said maybe then for support other

services was there anything that you had in mind? whether its from the clinical services or from the school that one could put in place to support these students?

Participant: I I'm not sure if the questionnaire can we go to to or to just give them you know a chance of or a number. You know those dialling numbers cause for a fact you know I said if you got any problems, you must give me so where we can have a line if someone else is is is really in a tight corner who would like to share. We can have that that line at the university even if it is in the department of nursing to call and then we assign certain people who are willing to assist like me.

For the fact that I said I'm willing to assist, I was in the middle of the night when they went to that funeral. The whole night until two am because they were high-jacked by the taxi men. They call me because I was at home because my mother was in Nyanga but I was in Mowbray. I drove to Mowbray, down to KTC where they were leaving in Cape Town to but they like that number where they can dial and then you know services like that. You know like life line, chat line where you call someone else. There people who are available because there are certain people say those you can assign to even you know this is the case then you know Dudu can talk to them. Either it's in our department or outside our department.

Just a line so that if they feel a too much you know hmm they can be able to taking a phone and say look I'm not coping in this sense and this sense. Like that student who disappear. You didn't know where the students are until I find out from Lentegeur then when I ran to whatever, the student, Sister Banzi told me that the student was depressed and the student was not. Then when I ran back to Lentegeur to find out what's the name of the student. No student know what's the name of the student so I start with the address. Can't go to the university until somebody phone from Tygerberg and so it was my friend. I ask her to meet me in Phillipi. That's how I know where the student stays then I drove from there. No, no then I phoned the sister and the sister told me she's admitted to D12. Then I drove after supper I drove to D12 then when I was there I could see that no she was very sick. I spoke to Morris. Morris was my lecturer before. She, she's in charge of D12. She said no Dudu she's not ok. this child is very sick. Then she tjoep, tjoep, tjoep to me then then I left. Then I came back. Then when I came back she couldn't do anything but she could write. We could communicate in writing. She told me what was wrong xxx and then I said where the

parents? The parents she doesn't want them to come and see her and then I told her you have to. I wrote there and I gave it to her. She gave me and then she gave the number and then called the parents and the parents came the following day. She died.

Participant: Yes, yes, yes. Then I told her that she has to. I'm sorry for that that I have to phone home that that the doctors, everybody was telling me, that nobody visiting her. She doesn't want.

Interviewer: Don't you feel for you that is very hmmm strenuous the mere fact that you already got all the other work?

Interviewer: Now also having to do all this here because it sounds like you go the extra mile you know.

Participant: Aaah I don't think so. It's it's I would say its strenuous because when you doing it without thinking of they need. There's a need for for them to do that then hmm that's why I couldn't even do it, like writing it in paper and and some of the things that I came across with them that I need to but for me for me it is a good reflection if I I can write a book you know if very interesting. When I look this is what happened here, this is what's happening and this this is what this. So it's like very strenuous I must say but I don't feel it in this way because it's like you have done something that you're skilled for.

Remember I I'm the fact that we've trained that became psychiatric nurses, some other things like that, we must understand that other people are saying aaah Dudu I'm not going to know. I'm not going to talk about that. This is your case. That's friends but but we all trained we all registered nurses, they say uh uh remember you like to listen to people's problems we don't. So learnt understand people it's true.

So we can't all be the same you know so that's why I'm saying that aaah I might do it but I'm doing it because of some other times you don't have a choice of saying no I can't do that or whatever. But for them given emotional support, that line if you asking me in the question something that they can be even call and then say that this is my name, can you call me back. Then we know that if we have time hear the students that are in need so who can hmm be assigned to them and...

Interviewer: Ok so that would be at the university?

Participant: Yes

Interviewer: Right and at the services do you see the same sort of thing happening at the services or is there something else if we were in an ideal situation?

Participant: Hmm, you mean at the (pause)

Interviewer: to support the student because I mean although you where there you affiliated to the university does the services also have a role to play to support students?

Participant: Yes e services is supposed to play a role. Those are the ones I'm saying they are not in place.

Interviewer: but what do you see what because I'm trying to develop a model so I want to see what do you think should be there?

Participant: is this a system what I'm talking about. The one what must be a dialling line

Interviewer: so the line would be for the university?

Participant: Yes

Interviewer: And you see one happening at the services?

Participant: yes

Interviewer: ok. Is there anything else that you could see between either the universe of the school or the services that you can put in place?

Participant: I don't know, I don't know about the questionnaire the beginning that if someone would need that service so that we can be able to to know the number. So just give all the students when they starting at the beginning that if people can fill in this questionnaire who will be in need or e assisted in in anything emotionally and all that. This service is available so that we can see who are the people that we expecting, who will be in need then we take it from there.

So we got two hundred students these are the students that has responded that in terms of e e emotional support definitely I would need and then you just give a line just briefly if you want, in which way? not in terms of financial but just general.

Interviewer: So what you saying in like a needs analysis?

Participant: Needs analysis

Interviewer: To find out from students [participant; from students] ok what type of support they'll need

Participant: what type of support they'll need. and then we will take it from there to know if hmm because not all of them. I've met students who are very strong irrespective of what circumstances they coming from and those are the students I use. Then we take that one, I used to do that and then we mix them psychologically and then I know this one is weak then I take that then I combine them and then I keep them together and then off

Interviewer: Is it almost like a buddy system?

Participant: yes a buddy system so I'm not actually there but them see them not being aware and I've done it several times. Someone doesn't have money and this one doesn't have lunch to eat, this one does bring. That is obviously they'll end up sharing but they not aware that I've done it. Should just discuss it. So if this one is this then they end up phoning each other. They all end up eating together because I'm telling them what is meant by support. Doesn't need to be me. It can be someone that you close to so long as you you saying that no, no, no why then others say no but Ms Dudu never said anything to us. I said well you never said anything it's just that if you've got something you can share apple, drink, juice

Interviewer: and that would work with the same for emotional? if they had any problems?

Participant: They had any problems then they end up having sort of a group. hmm I've done that and it work and there is still seeing that if it was not because of that I wouldn't have done that. because I've started to have interest to go to work because I know this one, this one is on duty. Can you have same off duties or things like that because now we're buddies [pause]

Interviewer: hmm sounds very good is there anything else you can think of before we conclude?

Participant: n n no just feel better because I spoke about it. Don't, don't speak it to anyone [laugh] I am like that [laugh] so so they are ok now I've spoken about it so so now ts this is how it's it's happening

Interviewer: so the interview in itself... just being able to talk about it

Participant: ja

Interviewer: of what your experience

Participant: yes its like its like something that I would never ah say it to anyone. You know why must I tell people that I do that. But now it's like I'm seeing that its ok ja I've done that. Alright this is what happened ja ok, so the otherwise is don't think so sit and talk to anyone ja but must say from then them ah ja they they talk about it and they give me the idea of of of what they are experiencing.

So that makes me share myself at ease, so keep me, keep on going to say who is coming and hmm ja they also inspire me to do this, show its like that because from what they are saying and those who are troublesome and say ja because of you you told me that it's not gonna attack me anyway and they said [laugh] they is say right way the fact that they laughing at each. They laughing at that knowing that even though I didn't say nicely I to them they were its like ahha hh a mother and a daughter or a mother and a son relationship. So they saying that but then I said you calling us, then they says this no sometimes. hmm I do that because I wanted to to make you feel how important it is to you know to do things the way it's being done because it its not not always the case that we must always hide behind our pains and emotions and all those things. The only thing that we need to do is to ventilate feelings. They always say no Ms Dudu is going to say we must ventilate [laughs] so now it sounds like a joke thing ah you must ventilate. So I know what they always say to me and all that and sometimes when I'm quiet they say but why Ms Dudu you are quiet today? and I say ah today I'm quiet [laugh] so they tease me before sometimes and I say because why I'm trying to be silent. It's part of psychiatry, so all these I always tell them when I'm quiet I'm trying to [inaudible]

Interviewer: sound like you have a very good relationship with them

Participant: yes I that I I must say yes



Interviewer: and it probably makes their stress, you know, probably much easier in the setting.

Participant: yes yes yes I must say

Interviewer: Thanks very very much for [participant: pleasure] agreeing to participate in the interview and for participating you know the information has been very valuable



**EXAMPLE OF A TRANSCRIPT- SEMI-STRUCTURED INTERVIEW WITH A  
CLINICAL STAFF MEMBER**

Archival #: IILHO2
Site: Office in College building, Lentegeur hospital
Data collector(s): P Martin
Date of data collection: 20 December 2011
Transcriber: P Martin

INTERVIEWER: As I have explained to you the study is about emotional support. I'd like to know what are the emotional issues that you are aware of that the students that we place here that they experience -whether it is from other people or from the students themselves?

RESPONDENT: With the students, when they first come it is my introduction and my orientation about Lentegeur of what to experience because for them it is a first experience ever in a mental health hospital or psychiatric hospital. And most of them will come with a stigma related towards it, and so my introduction is basically not just to inform them what mental health is, so that they don't come with that negative impact into the ward or with stigma, especially when working with outside or [fellow] colleagues in the fourth year some of them give them negative feedback about mental health. So if they do come here I try to make it as simple as possible in terms of what mental health is about and what to experience.

And I think so from there once we've placed them into the wards we introduce them to the wards as well. And for some of them I did receive feedback where the first week was very emotional and they were very scared. Some of them were crying. They wanted to leave the ward and the ward sister would phone me and tell me, you know what, we have a problem with a student. They are very emotional and they're scared. Is there anything that I can do, maybe change the ward. Then I would advise the Sister, you know let him just be there for the week and let him work the weekend and from there lets see we can see the following week what we can do. I'll give feedback at the end of the three week that the student s didn't want to leave the

ward, they enjoyed the ward,. More or less they discovered something new about mental health.

So my introduction is there to give them an honest opinion of mental health, what it's about, what to expect when you go to the ward. When you go to the ward, don't be surprised, but you will be surprised by certain aspects of ... maybe the patient's mental defect or physical defects so especially in terms of IDS and I'll tell them that the patients are in inverted commas they normal. It is either certain things that have happened in their lives that they are like that. But the best part is I would say that in terms of emotional support, I ask the staff to send the students to me and I try to assist them and help them and explain to them about mental health what it is about. And for some of them by the end of the day or by the end of the semester they are really grateful from nursing staff as well when they come to me and they tell me, no, they really enjoyed it and they didn't know that this is what mental health was about. So in terms of what they have experienced from outside what the stigma was about mental health to what they've experienced inside it is two different things.

It is kind of a positive feedback because one of the students that we had that was a fourth-year student and she was just finishing off her vacation, her November vacation studying placement and she told me that you know what she didn't want to work in the psychiatric wards because of certain reasons that she was scared of. And I explained to her what forensics was about and I just told her that she must just take it one step at a time. You're almost there now and I guided her through it and then at the end of the year she came to me to say, thank you very much for helping me, and understanding where I'm coming from, but also for encouraging me so. That was a big boost; not just for me but for Nursing itself that we are there to spot the difficulties of the students, especially in terms of emotional support and of them being scared a bit of coming to the ward. I try to make it as comfortable as I can. And also the staff they try their best. But , you know, certain things they are never saw because they base it ... Mental Health... like I said, you based it on the stigma, but they base it on the movies what they watch and they come with that philosophy and that opinion of it. So we try to not change them, but I always say experience mental health for yourself and then you tell me what it is about. What you come in, forget it and leave it outside. Come in with your own mindset and own thinking. And from there at the end of the day tell me what it was for you.

INTERVIEWER: You've mentioned... so, it looks like you're the support person here?

RESPONDENT: Ja, you can say that.

INTERVIEWER: Okay. You mentioned that some of them when they come...in your experience, have you ever found that students right up to the end, in your experience, they still say that, I never want to come back and work here?

RESPONDENT: If I can ... even our students and our com serves at the end of the day I would ask them would you actually like to come work at Lentegeur. For quite a bit of them they would say "yes". And there's a few of them who would say that they want to get some general experience. They want to know... you see, there is also a stigma between general experience and psychiatry because there's also a comparison that you lose your general skill in psychiatry, and the stigma is also that general don't know how to put an IV. You as a professional nurse, do you know how to put an IV? So there's also that type of professional stigma between hospitals and between colleagues which we can, I mean, I personally experienced it as well.

Now with some of the students, they would actually put Lentegeur as a first preference in coming back as doing community service and for some of these students they would say no, psychiatry is not for them. Their heart is in midwifery, but not negatively saying, this is not for me. I think so some of them have already made their mind up by the end of the fourth year where they would like to be.

But I think so from psychiatry, we had ... I had quite a bit of positive feedback in terms of psychiatry that students would want to come to Lentegeur, like I said in com serve or even remain here after com serve at Lentegeur or if they don't get a place here in any of the other psychiatric hospitals.

So the feedback is quite positive and I think so also with the groups that you're running and in terms of all the programme for in terms of psychiatry and educating the students. So I think it is quite ... it opened up quite well in them getting a better understanding of psychiatry by the end of the semester.

INTERVIEWER: So what you're talking about now is the skills development that we have.

RESPONDENT: The skills development, yes.

INTERVIEWER: That we have at the university; that supports them when they're coming for it then at least they know. Is that what your saying?

RESPONDENT: Yes.

INTERVIEWER: Okay. Tell me do you see Lentegeur having a role in student support?

RESPONDENT: Yes, we do because we do have a role in terms of student support , but like I said, it is not mentioned if a student needed some sort of support. We will just go to... the ward will normally phone me and tell me that you know a student needs some sort of assistance they not comfortable working in the ward. So either I intervene or the operational manager or the professional nurse in the ward will assist the student right through the first week and through the second week. So they are assisting ... but I don't get any feedback unless, you know, the student really cannot manage then I will intervene or I'll get some sort of feedback.

But as I understand, I was speaking to one of the operational manager's last weekend and we get nurses who go all out to know their students – in and out. What they're afraid of, family structure, social life and how they can assist so we do get dedicated professional nurses and operational managers. They're willing to sit and listen to the student and they will try to assist, but I haven't collected data on that. It would be something nice to look at. But no I haven't collected. But in terms of that I do get some sort of feedback...

Hmmm, I would actually speak to the students and ask them how it is going in the ward. And they'll tell me, sister so-and-so assisted me and helped me and I'm quite comfortable and they found it very much more easy going through their three-week programme and the ward they go through, yes.

INTERVIEWER: So the support comes from, I'm just trying to think now, the support comes from the ward Sisters and then the staff in general ...

RESPONDENT: Yes.

INTERVIEWER: ...and then you are there when they can't manage.

RESPONDENT: Yes.

INTERVIEWER: If the student said I can't and the Sister says that the student is not managing, do they actually tell you exactly what the student is not managing or is it about the work itself or is it just the fact that they cannot cope with the type of patient or ..?

RESPONDENT: Like I said, in the first week of their placement, I get phone calls. I get lots of phone calls in terms of the students are scared and they are not managing, but by the second week it is fine. If I do phone or when I do follow up on this particular ward the staff will tell me that the students are fine. They're okay. We assisted them, we orientated them and we guided them through and they say no, it is fine. So I've never had a situation where the student could not manage and I had to take the student out and place... so the staff at ward level were a real benefit to me. They are also much like a support structure because they're working hands on with the students as well. So, like I say, I never had that problem, but I know that there were students that came from either the university or college who had some sort of problem, also psychological problems and it wasn't reported to me.

But when I interviewed or spoke to the students, they would tell me that they have certain problems and that they're under medication for depression and that. So I would try to make it easy, simple and comfortable for them, but I will always advise them that if you still cannot manage in the ward then come to me and we can speak about it and then maybe we can try and speak with one of your supervisors and see how we can assist you in putting you in the ward that it will actually be a benefit for you and allow you to ... that will be much more assisting to that student, but I ... why I am telling you this, because I think it was last year that we had a student who broke off with her boyfriend and she didn't take it very well. So she was very emotional and I had to guide her through that, but I didn't have any problems because, I believe that one of the supervisors also knew her, she was a very intelligent student as well but she had a bit of problem, but I didn't receive any complaints from the ward. Like I said, my doors are always open. Yes, that is how it works.

INTERVIEWER: So, what you're saying is that people come with pre-existing or maybe come with their social, their personal, come with those issues?

RESPONDENT: Yes, they do.

INTERVIEWER: Okay, so it is not really related to the patient...

RESPONDENT: Hmm. Sometimes it is their own...

INTERVIEWER: ... their own issues. Okay, do you see Lentegeur as having a role in student support? You know, because what we're talking about is that it sounds like it comes from the ward staff, I don't know if that is part of their job description. So it is almost like ad hoc. That is the impression I'm getting. It is not really formalised to say that.

RESPONDENT: Yes, it's not really in black and white. We know that we're a training facility and part of our job description is also provide education and training at ward level for our students, but in terms of having a structured place for students, no, we don't have that. We don't have that. But I think the ward has taken ... the ward including myself have taken it upon ourselves to be that, but we don't have a proper structure.

INTERVIEWER: Do you think that would be something to look at?

RESPONDENT: I would think so. I would definitely think so. Apart from the hospital can provide that and also it would be a huge benefit for the student knowing that there is someone out there that understands me and there is someone that I can go to in confidentiality and can help me and assist me. So that will be a huge benefit for the students and it would be something that... in terms of Mental Health it would be something that's really required in lot of our hospitals as well – generally speaking too.

INTERVIEWER: Yes, because I'm thinking that hospitals have occupational...you know, the occupational health nurse and they have ICAS, you know, they have support structures there, but seeing that the students spend a large amount of their time here.

RESPONDENT: I'm glad you mentioned ICAS; like you said, we've got a [ ] staff but we haven't got a structure just for students where they can come and like debrief. You know, if they come here for a week here then we have a day when they come ... if they're in the morning at work till about 2:00 then from 2 till 4:00 come for a debriefing session at the end of the week and then tell us how it was or have the supervisor involved in there and talk to them how was your first week? What did you

learn? what were the positives? what were the negatives? what were your fears? and that debriefing session will work very well, because I remember when Ms Kathleen September we used to have a debriefing session every Fridays. We would come and have a debriefing session. I see that has stopped. All our fourth-years would be together at Lentegour and we would come and talk about what our experiences for the first week. As we went on and on, we assisted one another. We helped each other. By end of the day, we were strong physically, I mean emotionally and mentally we were strong. And I would think, having something like that just for students would be a huge benefit, because that is their time and space to talk about their problems or what they're going through.

INTERVIEWER: ... it was there but it seems to have fallen off. Did you feel you people coped better in the ward settings if you could talk about it and you knew you were not alone in that situation when you were a student?

RESPONDENT: I think that hmmm... you know for ... in our orientation in our fourth year that was in January, I think and when we would be ... I think it was September, Kathleen I think I cannot remember, so we spoke about our fears. We were in a circle and we spoke about our fears. There was a lot of emotion. A lot of the students were talking about emotion how scared they would be and because they did not know what to expect, because a lot of things on Mental Health.. with the stigma attach, we were scared of what may may happen or not happen. So we spoke about that and we encouraged each other there at that orientation. And then we bought the same thing back when we went to each ward where we were introduced at each ward. So Sister September arranged for that, for a debriefing session that would happen so it was very encouraging to know that you are not the only one that is experiencing this but we can encourage each other and each one has a different type of experience that they're going through, but what is severe for me might not be severe for you. And we assisted each other in that way, So to have something like that here...

INTERVIEWER: And based on your experience, what do you think ...because at the university we do have student support services, but the students mention that they do not get appointments when they need it. Say, they have an incident here and they would like to see somebody. They go to Student Support Service, they have to wait.

RESPONDENT: Yes.



INTERVIEWER: But the crisis is now. They need somebody now. Do you think that the university can offer these structures so that the School of Nursing can put it in place?

RESPONDENT: Actually, I think that should have been done a long time ago. way long time ago because you know we've got students not only in our fourth year but in first year that are staying at the residence that we don't know. There are so many things that are happening there that that structure should have been at the Nursing Department. It should have been there a long time ago to help our students even from first year as well. Because we got students that are coming from different provinces, different countries, as well as from rural areas. And what they experience in the hostel and in the urban areas for... some of them it is painful because they go through a lot. I mean, we do not know what's the ... whether there's maybe physical violence, emotional violence, sexual violence that they're experiencing. Something that would be vital for the student that can assist him or her in the first year right through the fourth year,. . So the Nursing Department, if we do have something implemented at the department I think it would be a huge plus for Nursing and it will take Nursing to another level, especially at UWC as well. So we should actually implement that.

INTERVIEWER: How do you see this structure, the ideal working? What do you see as the structure or any intervention at the school, how do you see it?

RESPONDENT: In that area, in terms of support... hmmm, I wouldn't say having a support group, but a support centre at the department for them that would be benefit... that would be a huge benefit because you know some of our students ... also the exams; after they've write the exams and they didn't do well then that support structure could be there in terms of the exams as well or even if they failed their practical and didn't do well in the practical we have a support structure there as well to guide them and shown them, Okay, where do you feel that you went wrong or what did you do? Because sometimes we listen to everyone's advice of how to do a procedure and then when we go there we get confused again. Ms A and Mr A, Ms B or C told us and then we don't know what to do. So we should actually ... to have the support structure therein terms of just supporting the student, it could be... it would be of a great benefit. But because I mean, we have 400/500 students and a lot of them are going through all types of pain. And it is difficult to ... they might feel

neglected. We don't want them to feel neglected. We want them to tell them, you know, the road ... it's a long road and you are going to experience some sort of difficulties, but there is a support structure that's here.

And I think what they're more afraid of is that will it be confidential. You know, if they see me coming through that building now... and one of my colleagues see me now... you know, how can we guarantee confidentiality? So I think so that is what people are afraid of. Even when we have our HIV testing at the university and when people go to the clinics, I mean, sometimes confidentiality doesn't stand.

INTERVIEWER: I just need some clarification...say, we have a support centre at the school, should it focus more on the academic aspects as you said, that if somebody fails they probably would be very anxious and would need some support, do you think it would then be... would it be different for students in their fourth year because the setting is different in Mental Health? You know, the other years, Midwifery and General Nursing, that is a whole different setting... do you see based on your experience that it would be any different or do you feel that students generally have similar, similar issues?

RESPONDENT: No, I think it would be a bit different, especially in fourth year and in terms of Mental Health, students find themselves experience certain things that they never thought that they would experience, especially in the wards and especially they tend to identify themselves with a particular, with a patient as well and I think that also can also be a separate structure on its own in terms of a fourth-year Mental Health student. Because we tend to find in the fourth year and we, like I said, students come with some sort of problem and sometimes it is emotional and having that there we can then refer to you or to the Department of Nursing and they can assist, you know, it would be nice to have a separate entity in terms of the fourth years because

You know, it is nerve wracking because apart from your tests, your assignments and your projects, you have to work with patients... it takes a lot out of you. And you just need to debrief and you just need to come to the support centre and say let me offload and see how you can assist me as well. I think it would be... I don't know in terms of budget, but if it could be allowed that we have, in terms of especially the fourth years, I would say we should do it.

INTERVIEWER: I am looking at the ideal situation where we have everything to develop this model to see what would be supported, you know, in an ideal situation. Is there anything else you can think of?

RESPONDENT: I think, you know, there are two types of professionalism ; one is in the hospital setting and one is in the academic setting. And if you would take that and can combine it and then use it in your in the support structure or tool for the students it would be very, very beneficial. Because like you, you got the clinical experience and you have the academic experience as well, so you can identify if a student would come to you and say, I've got a problem, then you've got all that knowledge that you can understand where he or she is coming from at a hospital setting and you have the knowledge of an academic setting of the stresses they related.

So I think if you were to develop that type of model it would be quite interesting... it would be quite very, very interesting and also the feedback from them what they think of it, would be very interesting.

But I would also say that if we can still continue with debriefing sessions, if our supervisors can come and pick a day where they would have certain hours allocated from maybe 2:00 till 4:00 from 1:00 to 3:00, and let's debrief and see what's our problems, because I have had a first-hand experience of dealing with learners from a high school that came part of community service that they had to do. And I asked them what is your opinion of mental health. And they told me a whole lot of things about mad people and asylum and everything. We had to put them in IDS wards. Unfortunately, the psychiatric wards, they wouldn't have really coped because they were Grade 8's so we put them in the intellectual disability ward's some of them it was and at the end of the day we had a debriefing session with them and some of them were scared, some of them did not know what to do and very emotional, and they didn't understand why the patient was coming to them. You know, so each day I work on that and he could see the progression and he understood what mental health was about to a certain extent. But when I asked them questions and during the feedback session that I got from them at the end of the week was they thought psychiatry was just this big wall around the hospital. They thought it was an asylum. It is just mad people running everywhere. And what they have experienced as to what they thought psychiatry was about was and what they thought a psychiatric patient was, were two different things. So they've gained something that they can

actually go back to the school and educate their colleagues about ... because at the end of day ... it is about education and your debriefing is also based on education allowing them to express their opinion what they think about without criticising them and then formally explaining to them what it was really about.

INTERVIEWER: You found that would those scholars...with the learners from the school and our students from Nursing school similar?

RESPONDENT: Very similar. I would say very similar that and if I were to take and do my orientation or induction with nursing staff that never worked in psychiatry, it is a bit similar as well, because they don't know, they haven't worked in a psychiatric institution. So when they do come, I explain to them and it is the same thing, it is the same theory that I use and they go through those emotions for a week or two and after that they're fine.. So I'll say the experience is very much alike and by the end of the day, they're fine.

But I think what you're doing is good and is an excellent idea of having a support structure for students because when I was in my fourth year, I didn't have support structure and when I go through an emotional state I would just talk to my supervisor. Ms September was my supervisor. She would in terms of a debriefing session, we would talk to her, but also I would talk to her one-on-one I would talk to her and if I had a bad experience because I know what I experienced in one of the papers that I wrote, it really affected me because I never did badly in a paper so I spoke to her and I was really emotional about it and no one could understand why I'm so down, why my appearance was like not depressed but sad and I spoke to her alone and I explained to her what happened and she confided in me and she assisted me as well.

So as much as we get... mentally it's draining working in the hospital or at a mental health clinic we've also got the experience of our academic experience which is also training in as well. And that is like creating a time-bomb that can explode at any given time and sometimes the student may just act out and we have to just sit and just listen and find out where the problem is. It could be that the work is too hectic or working in the clinic or in the end in the psychiatric hospital – that's hectic, but that is where you come and that's where your model comes in that's where we can provide that type of student support system in the hospital which has to be confidential,

confidential as well as at the university. I think it would be a great linkage between hospital and university to see how we can support the student, you know.

So what do we need? We do need support structures. We do need it as we got for our permanent staff. We do need it for our students. Because we need to continuously educate our students but having a support structure for them and having it in black and white - it will really be a benefit and it would also be a benefit to students understanding Mental Health a little more than just mental health could also be of just coming here to do my fourth year and going.

INTERVIEWER: So what you are saying with understanding comes confidence that type of thing.

RESPONDENT: Yes.

INTERVIEWER: I think we've covered all those questions. Lastly, I just want to say that I think that you are doing a good job. The mere fact that it is formalised, you are here, you know, to support the students.

RESPONDENT: Thank you so much. The thing is at our last meeting we said that we cannot work alone with our Head of Nursing, area managers and operational managers the professional nurses and staff nurses, we all need each other to assist so at the end of the day it's about synergy, that is what it's all about.

But I do hope for the students' sake as you've mentioned in the fourth year it is really a lot because you know, it's like I said, we are only hear in the residence about a student was raped or a student was intoxicated and was raped... we only hear it but ... they would carry that right through but when they come to the fourth year it is a lot to carry. and once they come into mental health and they identify to that particular patient then all hell breaks loose. And that's when we need that support structure quickly to try and nourish that student and help that student quickly before it actually goes further ...you know, and then... it is something we really need with for our students here. But also at the Nursing Department, because the Nursing Department is like you know if we walk so far for a tuck shop while you could have it right there and it would be a huge benefit for that student to get something...so, just like a tuck shop.

INTERVIEWER: It is a really good analogy.

RESPONDENT: We've actually mentioned that why should we walk so far when we could actually have something right here, even a vending machine. The same thing like a support structure. We have something right there for that student that student could come at any time... even a counselling centre for them. Even if they need to phone in and have a counsellor there at any given time would really be a benefit to that student, because we can't say what is happening at night, you know. Even for a fourth-year student, and boy, they've got a lot of baggage. Some of my colleagues as well were going to an emotional time and when it came to their fourth year it was like they were too scared that and they were experiencing things like self-mutilation and they and everything were too scared to mention it and too scared to talk about it and then students start gossiping about it and this and that and it becomes even a burden on them. And some of my colleagues I would sit and talk to them, you know, and try to assist them as much as I can, but you know all student s students actually graduated.

But we didn't know it was there. Only in our fourth year we realised that this student was actually thinking of suicide. This student was self-mutilating, this student was pregnant and didn't know how to deal with it. And that student, we never expected it from that student, but it happened. And she wanted to have an abortion, you would talk to her not to do it because of what is going to happen later on and when that student takes your advice, even you as a colleague giving her advice, and decide not to do it. So when it comes to the fourth year, they are discovering things about themselves that they thought that that they thought that they would never have experienced. And some of them would actually look back and say that someone in their family have that and that is another emotional burden on them, especially in mental health.

INTERVIEWER: Do you think that it is correctly placed – Mental Health in the fourth year? Do you think if you look at our curriculum, I digress, but this is important, if you look at our Mental Health curriculum, Mental Health is in the fourth year. So, do you think it is ideally placed?

RESPONDENT: I think a bit of Mental Health should be starting from your first year as an introduction and going right through until you come to the bigger picture of what Mental Health is really about. So that we can deal with the situation that a student goes through in our first year and guide them through that part... But we

also be careful that students don't abuse the system and make it as an excuse, we need to get, you know, have our proper documentation of that particular student, because like I said, with one of your students who are sitting in the fourth year was very depressed. You could see that and I had a student that had a problem with the spouse and she didn't know how to deal with it. She could talk to no-one and she confided in me. It was very confidential and she confided with the supervisor. And I supported her... we supported... I supported her in terms of what ward she must be placed in ... and how she can go about her working hours and I spoke to her supervisor and she knew about this particular student. So we tried our best with her and thank God, she finished her studies and she graduated and everything. That was great to see that she could come out of that and also that she could assist her spouse as well. So nothing is lost but everything is gained in Mental Health. If we can detect something early then we would know how to manage it later on.

INTERVIEWER: You get people that don't talk. As you said, you could see this person was depressed. What did you do?

RESPONDENT: With her, I explained to her and I said that I understood her problem and I didn't put any pressure on her that she has to and you must complete... I said, the best thing is to do what you can do and hmmm ...if there is anything that you are struggling, feel free to come to me, but also remember that there is a operational manager that there that can also assist you and the professional nurse that can assist you and know what you're going through. If you're willing to open up. But at the end of the day you welcome to come to me and I can assist you and talk you through it and guide you if it means that the ward is too much and is actually reflecting on something that is happening to you, maybe just take you out of there for a little while and place you in a ward that will be much more comfortable for you in a working environment, what is required of you in your practical placement. And we can take it from there and if you feel that we should inform your supervisor then we can sit together.

I spoke to a student once and only once or twice and after that I didn't get any negative feedback about that student or negative feedback from a supervisor. So but I always have an open door policy. I always tell the students any time, any given time, you're welcome to come and talk to me and we can see how we can work with your problem and around your problem and how we can go about assisting you,

because I don't like to see a student struggle but I also don't like to see a student abuse the system as well.

INTERVIEWER: Do you find with your open door policy that you do get students or is the ward staff able to manage the students or do you still get students who will rather prefer to come to you?

RESPONDENT: I think so, because how I normally get the student that would find it much more comfortable to come and sit and chat with me about what they're going through or even their experience in the wards is negative or positive, they would still come to me and chat with me. And yes, so I found it quite encouraging that they can do it . And yes, I also have staff that would also come to me as well and they would talk to me ... even if it means personal issues that I sit and chat with the staff. Like I said, it is confidential. I don't ... no-one knows about it. It is here... and you actually forget about it because you don't just remember.

INTERVIEWER: Sounds like they have identified you as the support person as someone...

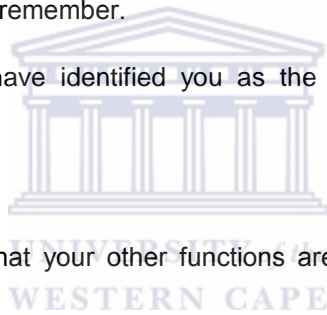
RESPONDENT: Yes.

INTERVIEWER: ... regardless of what your other functions are, they've identified you as the support person.

RESPONDENT: Yes.

INTERVIEWER: I wonder what is that about it? Is it the fact that you are qualified and trained at UWC or what do you think?

RESPONDENT: I don't know. Because I mean, I thank God for my personality that I 'm not a person that has a strict or a stern face, and I tend to open up to all of the universities and colleges, and advance students that come through, campus students have come through as well as students from Free State that come through... so I don't know but I just address them in a very friendly and calm manner and I'm obviously always there for you, guys and at any time, at any given time feel free to phone me. And the fact that I say call me by my first name, I try to make it much more easier. Rather call me on my first name. I said don't even call me Mister, call me Manesh that's fine and we go through it and then, yes.





INTERVIEWER: Okay. Thank you very much.

RESPONDENT: I hope that I've answered all your questions.

INTERVIEWER: Yes, you have. Thank you very much.

RESPONDENT: You're welcome.

